DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month McLAUGHLIN HELEN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perry Point bc If Under 1 War If Under 24 Hrs. 7. Ace in vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. APR 15 1 🗆 M 2 💢 F DE Country) T920 222 05 5846 Yrs. Director Usual Residence of Decedent permit, Page 1 and 2 should be fill d within 72 hours after death with the Maryland Department of Health and Mental Tygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director CECIL PERRY POINT MD1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? VA MARYLAND HEALTH CARE SYSTEM 21902 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married 1 X Yes 2 If Yes, Give 1 X Yes 2 No 44 If Yes, Give 944 Year or Dates 945 21215-0036 1 XXYes 2 □ No Specify: WHITE Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY CHEMICALS Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH McLAUGHLIN BRIDGET McGEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WINGATE DR., LINCOLN UNIVERSITY, PA 21902 FREDERICK SCHEING Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State FEB 2010 11, CATHEDRAL CEMETERY WILMINGTON, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee 19805 22. Name and Address of Facility M00784 MEALEY FUNERAL HOMES, PO BOX 2866, WILMINGTON DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Due to r as a insequence of): Pnysician SUPPOSION disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 X No
9 Unknown Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 5 Pending work? 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 00235 Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. VAM Registrates System, Perry Point, MD21902

DHMH 17 Rev 7/2009

State Registrar

STOP STOP

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State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		Cer	tificate of D	eath		Reg. No.		
Physi	ician edica	/	1. Decedent's Name <i>(First, Middle, Las</i> Patricia Dale	ey Moses				2. Date of Dea Month Februa	Day	010 	3. Time of Death
Exar			a. Facility Name (if not institution, give	street and number)						y of Death Cester	
Fune Direct			210-34-2002	7. Age (In yr. 71	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 02 24	1938	9. Birthpl Countr Mary	
(and 21215-0036) be filed within 72 hours after death with the Maryland ental hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		irector	Usual Residence of Decedent 10a. State 10b. County Maryland Worce: 10e. Street and Number	ster	rlin 10f. Zip Code			10d. Inside City Limits 1 ☐ Yes 2 🗓 N			
		≦	142 Teal Circle 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		21811 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et □ Yes 2 ☑ No Specify:			res or No- n, etc.) 14. Race - Amer Black, White		etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hyglene. 27 is marked other than "natural", or reumatic event, the Medical Exam		Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	ducation ide completed) College (1-4 or 5+) 5+	(Give	dent's Usual Occup. kind of work done o O NOT use retired) nistrator	luring most of work			ic sch	nool system
/land d be filed Mental Hy arked oth		o Be	17. Father's Name (First, Middle, Last) Jeremiah Daley				18. Mother's Nam Ellen N	1cHale			
, Mary d 2 should alth and h 27 is ma			19a. Informant's Name/Relationship (7) Robert Moses spot		142 Teal Circle, Berlin, MD 21811						
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of any injury or other traumatic even	,		20a. Method of Disposition 1 ☐ Burial 2 🎦 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State		sition (Name of matory or other plac Cremato	e)	Date 2010	20c. Location Salish	•	
Balt permit. Departi Import	ouce.		21. Signature of Funeral Service Livens	Eines (+)		501 Snov	7 Hill Rd	., Salis	<u>sbury, l</u>	onal A MD 218	Association 304
Pnysicia) Medie			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the d ne cause on each line. a. Due to (or as a o	Homa,		g, such as cardiac		rest,		Approximate Interval Between Onset and Death
Examir	ner	Je l	Sequentially list conditions, if any, isauming to immodrate	b. — Date to for the among						+	
8760 ifficate be executed ng physician and as the burial-transit		Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a cons	sequence of):						
8760 ifficate be e ng physicia as the bur		Medical									
		≂ ।	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3 🛚	Ctopic pregnand Other (specify)		23d. Date of delivery Month Day Year			
S, P.O. res that the signed by t		ģ	Part II. Other significant conditions of Recent CV+	ontributing to death but not A and GI	resulting in the l	the underlying cause given in Part I. 23			23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☒ No 3 □ Probably 4 □ Unknown		
Division of Vital Records, P.O. Box 6i To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attendir commelted filled in by the funeral director, page 2 should be detached for use		Completed	BIL Concer	4 and GI exhamp D	VTS			perfo	. Was an autopsy prior to completion of cause of death? Yes 2 X No 1 Yes 2 No		
ital ician: certific		Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth	ace of Death (Chec				
on of Vinding Physith. After this of tuneral directions of the physical di		cate: To	1 ☐ Yes 2 ☑No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	1 ☐ Inpatient 2 28a. Date of injury (Month, Day, Year	28b. Time o	f 28c. Injur	y at		dence 6 LJ Oti)
Division of the state of the st		Certificate:	3 Suicide 6 Could not t 4 Homicide determined	e 28e Place of Injury - A	t home, farm, strecify)	reet, factory, office		28f, Location (S City or Tov	Street and Numi vn, State)	ber or Rural	Route Number,
ne Hospita n 24 hours ne Funeral		Medical	(Charle 2 Modical Evan	sician: To the best of my kr iner: On the basis of examin se Practioner: To the best of	ation and/or inves	stigation, in my opini	on, death occurred a	at the time, date a	and place, and d	due to the cau	use(s) and mariner stated.
O' Po se this		_	29b. Signature and title of certifier	Arstner M.	.0	29c. Licens			29d. Date sign. 2/5/	4	Day, Year)
181	~		30. Name and eddress of person who	completed cause of death (RZADON N	Item 23a) (Type,	Print) 4 Healthy	vay Dr. B	erlin, I	MD 2181	1	
	Stat istra		30. Name and eddress of person who MEUSSA 31. Date filed (Month, Day, Year) FEB 0 2 2	32 Registrar's Si	gnatu.	are					

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Felicia Dav Physician/ 710 PM 12 2010 Elizabeth Nornhold Medical Marianne 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Memorial Hospital de Grace Harkord Havre Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🗆 M 2 💢 F Months Hours Min. Country) **Director** 195-28-3276 03/11/1936 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at with the Maryland Director 1 Yes 2 No MD Cecil Perryville 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral Channel Drive 21903 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 ¼ Widowed 4 ☐ Divorced Completed Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public School System Secretary Be Page 1 and 2 should be filed went of Health and Mental Hylem 17 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Paul K. Reider Florence Copenhaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell L. Geiger (Son) 505 E. Craighill Channel Drive. Perryville. MD 21901 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemežery 2/17/2010 | Palmura, Pennsulvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 21 Signatury of Funeral Service Licensee Washington Street. Havre de Grace 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition Physician/ hronic Obstructive hung Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): sician and bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician or use as the buna Physician/Medical 1x 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown 9 Unknown 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 틒 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed H13702444 2 🗆 No 1 Yes H800404400 DISTONDO, THOMAS 25. Was case referred to medical Be 26. Place of Death (Check only one) 02/11/10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred injury within 24 hours a To the Funeral DACCT# F completed filled inos 02. work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Hospital c73 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of Certifie 29c. License number 29d. Date signed (Month, Day, Year) tebruary 13, 2010 40054439 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel An and 48 North Avenu incental Giminister Do 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 25 201 10 Sen Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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NORNHOLD, MARIANNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Palmer 2-19-2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Care Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🖺 F 577-18-2429 98 5-20-1911 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Fairfax VA Alexandria 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò "natural", or items 23a 7161 Silver Lake Blvd 22315 Funeral within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗽 No Specify: þ 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie K. Trussell Emma Jane Mills ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 922 Pontiac Avenue Frederick, Maryland 21702 Dorothy Ahalt Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-2-2010 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem Fort Myer, Virginia 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service 106 East Church Street Frederick, MD 21701 M01176 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Coronary Artery Disease Approximate Interval Between Onset and Death Coronary Artery Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertention Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the sid be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐Yes 2 ☑No 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 2 No 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director. p To the Hosp within 24 ho To the Fune completely f

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Montclaire Avenue Frederick, Maryland 21701 Dr. Syed Haque MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD.

5

Dr

29c. License number

D0054636

29d. Date signed (Month, Day, Year)

2-19-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lawrence Gilbert Pilkerton ebruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARLES APLATA ENTER 1 V15TA K | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | December 26, 1917 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ▼M 2 □ F 92 216-10-6294 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, it a fection Examine must be notified at 1 ☐ Yes 2 ☐ No Directo MD Charles White Plains 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9918 Rhodes Way 20695 USA LAWRENCE MEH Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Missile Technician MD National Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thomas Pilkerton Agnes Regina Fladung 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann Campbell/Daughter 55 Cedar Tree Lane SW, Calabash,NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1t Burial 2 □ Cremation 3 □ Removal from State Christ Church Wayside 2/12/2010 Newburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Service Licensee 22 AREHARI ECHOLS FUNERAL HOME, P.A. M00945 and C. E. ha St. Mary's Ave. La Plata,MD 20646 Approximate Interval Between and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each fine. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or nsequence of) Examine the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 D Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes s certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 2 No 1 □Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 2 X No 1 🔲 Inpatient Certification: To 27. Manufer of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 ESM 10 cause of death (Hem 23a) (Type Square Suite 103 Walder Wathen Registrar's Signature State 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Certificate of Death Reg. No 2 0								0550/	
	Physicia	an	1. Decedent's Name (First, Middle, Las Kallicharran	Month Day Year										
	/Medic	al		- street and number)							1	ounty of Dea	8:00PM M	
	Examin	er	4a. Facility Name (If not institution, give Calvert Hospice				Prince Frederick					Calvert		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	hday)	If Under 1 Year Months Days			B. Date of Birt (Month, Da	h v. <i>Year</i>)	9. Bi	rthplace (State or Foreign	
	Director		369 10 1469	XM 2 F	59	Yrs.	Worth's Days	riouis		Oct 4,	1950		yana	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Loc	ation						10d. Inside City Limits	
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	or 28a	Director	10e. Street and Number				10f. Zip Code				0	en of What C		
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	er dez items	Funeral	11. Marital Status	12. Was Decedent I		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Ori n, Mexicar	igin? (Spec n, Puerto R	ify Yes or No ican, etc.)	- 14	4. Race - Am Black, Wh	nerican Indian, ite, etc.	
200	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2√√1 If Yes, GiveA X Year or Dates:	10	1	1 ☐ Yes 2 ☐ No Specify:				Specify: Indian			
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V	iled w Hygie ther th	ပ္ပ	12 17. Father's Name (First, Middle, Last)		PTE	ecne	nic	18. Mothe	er's Name (First, Middle,			.ve	
	d be f ental ked o	To Be	Santlall Pers	_					Raout	ie Sir	ngh			
ary	2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Eventral must be notified at		19a. Informant's Name/Relationship (Type. Print)	19b	. Mailin	g Address (Street &	and Numb	er or Rural	Route Numb	er, City or	Town, State	, Zip Code)	
≥ .	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Tej Persaud (Son)				King					ck, MD 20678	
ore	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐	Removal from State	20b. Place of cemeter	f Dispos ry, crem	sition (Name of natory or other place	e) :	Da	te	20c. Loc	ation - City o	r Town, State	
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סר	ng Phy ter thi neral o	n:T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		Time of Injury				8d. Describe				
Sio	tendir eath. or: Ai the fu	catic	2 Accident investigation 3 Suicide 6 Could not b	n			M 1 🗆	Yes 2□					D 1 D 1 M 1	
DIVISION OF	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Certification: To	4 Homicide determined	28e. Place of Inj building, et	ury - At home, fa c. <i>(Specify)</i>	arm, str	eet, factory, office		2		Street and wn, State)		Rural Route Number,	
	spital		29a. Certifier 1 X Certifying Pi	nysician: To the best	of my knowledg	e, deatl	n occurred at the ti	me, date a	ind place, a	and due to the	cause(s)	and manner	as stated.	
	n 24 h	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner st		nd/or in	vestigation, in my c	pinion, de	ath occurre	d at the time				
	Vith Vith Com	Ž	29b. Signature and title of certifier	en A			29c. Licens D173					e signed <i>(M</i> o Teb 5,	onth, Day, Year)	
			Loga a.	Valle	141	(75								
1	321.		30. Name and address of person who Raymon A. Noble	completed cause of c , MD 238 M	errimac	Co ₁	ırt, Prin	ce Fr	rederi	.ck, MI	206	78		
Ì	Sta Registi		31. Date filed (Month, Day, Year)		ar's Signature									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2:07 P. FEB. 2010 В. QUILLEN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days 1 □ M 2 🗓 F Yrs 88 DELAWARE 221-12-8102 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🔀 No DELAWARE SUSSEX SELBYVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30280 JAY PATCH ROAD 19975 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HUGH STEPHENS FLORENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JUDY Q. JARVIS/DAUGHTER 30296 JAY PATCH ROAD, SELBYVILLE, DE. 19975 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State REDMEN'S CEMETERY 2/12/10 SELBYVILLE, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 1701343 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Erner University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical

Physician /Medical Examiner

physician and

certificate has

To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica

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completely

Box 68760

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Records,

Division of Vital

law requires that the death certificate be

The

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

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Baltimore, Maryland 21215-0036

Pages 1 and 2 should

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Examiner Physician/Medical Be

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Completed

Certification: To

Medical

9 Unknown

examiner?

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

1∐ Yes 2⊡No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a

Hospital:

1 Inpatient

and manner stated.

Date of Injury (Month, Day, Year)

31. Date filed (Month, Day, Year) FEBUS

5 Pending investigation

6 Could not be determined

2 ER/Outpatient 3 DOA

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Man	yland / Dep		lealth and M	lental Hyg		05509
			Hegistrar Decedent's Name (First, Middle, Last	st)				2. Date of Dea	th	3. Time of Death
	Physicia	an	FRANCES	MAY	RO	(TO		Month Feb.	Day Year 19. 2010	12:50 AM
	/Medic				no		r Location of Death	r.cn.	4c. County of Deat	10000
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- 13			2208 Harkins 5. Social Security Number 6. S		n yrs. last birthday	+	ylesvill If Under 24 Hrs.		Hari	holace (State or Foreign
	Funeral		1	DM WIE	Q7 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day		hplace (State or Foreign untry)
* =	Director		217-03-0426 Usual Residence of Decedent		97			10/10/	1916	aryland
	and w		10a. State 10b. County	10	0c. City, Town or L	ocation				10d. Inside City Limits
	sho	5	MD. Har	rford		τ	Pylesvil	10		1 ☐ Yes 2 No
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	tem tem	une	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
98	or t	Y Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2X No	Specify:		Specify:	White
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пd	be fill doth	Be	17. Father's Name (First, Middle, Last		TT 3					Nichols
<u>la</u>	should be nd Mental marked c	2	James	Louis	Howard		Selen		atherine	
Maryland			19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State,	
	and 2 lealth a m 27 ts		James E. Rood			8 Harkin	s Road	Pyle	sville, M	D. 21132
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item any Injury or otha once.		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	ce) Feb	Date 27,	20c. Location - City or	Town, State
9	Pages nent of int: If It iry or o		1. Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	THemoval from State		n Cemete	20	10	Dundalk,	Maryland
₫	permit. Page Depertment Important: If any Injury o		21. Signature of Funeral Service Lice			22. Name and Addre			rtz & Son	*
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	I VERM		200 Rod Story the disease or com	polications that caused th	e death. Do not e	Home, F	no such as cardiac	or respiratory ar	rest.	Approximate
1 8			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on ea line.	•	itor tho mode of dy	.,			Interval Between Onset and Death
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	/Medical		resulting in death)		consequence of):					.4
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×	death certificate I e attending physi ed for use as the b	Physician/Medi	IF FEMALE:	23c. If yes, outcome of					23d. Date of de	livery
Вох	atter for u	iar	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 : 4□Pregnant at tir		☐ Ectopic pregnanc ☐ Other (specify) _	у		Month	Day Year
	0 0 0	sic	1 ☐ Yes 2 ☐/No 9 ☐ Unknown	9□ Unknown						
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5	Physician: r this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpati	ent 3 DOA Ot	han		dence 6 ☐Other (Sp	ecify)
ō		-	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju			how injury occurred	- ,,
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₹	or Attendent efter deati Director: in by the	ŧ	4 Homicide determined	building, etc.	(Specify)	street, ractory, emoc		City or To		
	To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by				more on the second		Contract of the Contract of th		4.5 4	
	t hou tune	edical	(Check only 2 Medical Exa	hysiciam To the best of a miner: On the basis of e	examination and/or	investigation, in my	opinion, death occu	rred at the time,	date and place, and du	e to the cause(s)
	To the Hospital within 24 hours e To the Funeral I completely filled	edi	one)	and manner state	ed				und Data signed (Max	th Oan Varal
	To t To t	Σ	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mor	ioi, Day, Year)
			I Wand Klee	2 m		D3	1295		2/19/10	
			30. Name and address of person who	o completed cause of dea	ath (Item 23a) (Typ					
			1.0	mo 5701	1 Kenwo	1 Ave	Bout 1	NO 312	o €0	
-19	g (n) ≥ St	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	0 00				
	Regist		FEB 25	2010	u B. 1	parle				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:40 PM Physician/ George Frederick Rubeck rebruan Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min Dec. 3, 1928 Marv1tand 215-26-8425 81 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director Maryland Washington County 1 ☐ Yes 2 No Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 11821 Robinwood Dr. U.S.A. items 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. ı "natural", or item edical Examiner n Armoed Forces?
1 12 Yes 2 1 8 5 8 1 Yes, Give 1 96 8 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Chief Petty Officer U.S.Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bruce Edward Rubeck Mary Jane Harnish Rubeck 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Rubeck-wife 11821 Robinwood Dr. Hagerstown, MD 21742 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot United, Charch of Christ Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-17-2010 |Cavetown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ouglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a conseduence of law equires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) ed by the a Unknown 9 Unknown P.O. teen signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an pate has b death? performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

▶ To the Funeral Director: After this certific Completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify, 1 \(\text{Yes} 2 🗆 N 욘 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Dea 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 C Hatural
2 Accident 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier D62588 on Rusos of person who completed cause of death (Item 23a) (Type, Print) 251 E. Antietan St HTIQUE MBAQUA MA

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 16

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	8.1	State Registrar 1. Decedent's Name (First, Middle, Las.	State of Maryland / Dep. 29d per dr., g901,0	tificate of	2. Da	ate of Death	No.	3. Time of Death
Physici		Junior Arbine Ru					Day Year 4 2010	11:00 A ^M
/Medic Examir	_	4a. Facility Name (If not institution, give		4b. City, Town, o	or Location of Death		4c. County of Dea	
, Y	** *	Coffman Nursing H		Hagersto	own		Washingt	on County
Funeral Director		5. Social Security Number 6. Se 213-16-0823	x 7. Age (In yrs. last birthday) ŽM 2□ F 88 Yrs.	If Under 1 Year Months Days	Hours Min. Set	ate of Birth fonth, Day, Ye 17,1	9. Bin 921 Mar	thplace (State or Foreign buntry) y land
D		Usual Residence of Decedent			bej	· 1/91	. 721 Hat	
gas 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. At the filem 271s marked other than "natural; or items 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at)r	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes X☐ No
the M	by Funeral Director	Maryland Washingto	on County Hagerstow	10f. Zip Code		10g	Citizen of What Co	
3a or	ΙΩ	404 Chartridge Dr		21742			J.S.A.	,
death	nera	11. Marital Status			Hispanic Origin? (Specify Yean, Mexican, Puerto Rican,		14. Race - Ame Black, Whit	
or ite	y Fu	1 ☐ Never Married 2 🂢 Married	1 XYes 2 No/ 2	1 ☐ Yes 2X No		, 616.7	Specify: W	
hours tural',	q pe	3 Widowed 4 Divorced 15. Decedent's Edi	Year or Dates: 1944	dent's Usual Occup	nation	166	o. Kind of Business	
thin 72 hours aff e. an "natural", or Medical Exam	Completed	(Specify only highest grad	de completed) (Give	kind of work done DO NOT use retire	during most of working	100	, King of Business	midustry
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ould be Mental arked o	2	Edwin Raymond Ru			Elsie Marie			
d 2 should be filt th and Mental Hy It is marked oth traumatic event	i I	19a. Informant's Name/Relationship (7) Marlene E. Russel			and Number or Rural Rout			Zip Code)
1 and Health tem 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	e Dr. Hagers		Location - City or	Town, State
ages ant of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State Cm + hohu	natory or other pla	cory 2-11-20		ithsburg	
permit. Pages 1 and Department of He Important: If them any njury or other shorts.		21. Signature of Funeral Service Licens	see 2	2. Name and Addre	ern Blvd. Nor	as A. F	iery Fun	eral Home
		23a. Part1. Enter the disease, or comp	ications that caused the death. Do not en				,CLS COWII,	Approximate
Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line. a Possuble Strok					Interval Between Onset and Death
/Medical		resulting in death)	a. Due to (or as a consequence of):					week
Examiner	_	Sequentially list conditions,	b. Due (o as a finsequence of):					wells
bed nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		and be me	EMBOLL	()		weeks.
be executician and	Examin	that indiated events resulting in death) Last	c. Due to (r as a consi quence of):		CELLISOR	/		war.
cate be exphysician the buria	icai	(d. DEMENTIA					
certifica Iding ph	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				23d. Date of de	livan
the death cert y the attendin iched for use	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnanc Other (specify)	у		Month	Day Year
requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Ď	Part II. Other significant conditions of	entributing to death but not resulting in the u	nderlying cause gr	ven in Part I. 2	3e. Did tobace		o the cause of death?
The lar	Completed					4a. Was an autopsy performed Yes 21	prior to death?	utopsy findings available completion of cause of
nysician: Thanis cartificate	Be	25. Was case referred to medical examiner?	Hospital:	1 04	26. Place of Death Che			
Physician: this cartific ral director.	. To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of	II 3 DOA	Nursing Home		e 6 Other (Speniury occurred	ecify)
Attending Phyrdeath.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Wo	rk?]Yes 2 □No	, , , , , , , , , , , , , , , , , , ,	injury coodinou	
To the Hospital or Attendir within 24 hours effer death. To the Funeral Director: Accompletely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	ocation (Stree lity or Town, S		ural Route Number,			
spital or hours en ineral D	ai Ce	29a. Certifier 1 PCertifying Phy	vsician: To the best of my knowledge, deat	h occurred at the ti	ime, date and place, and du	ue to the caus	e(s) and manner a	s stated.
the Ho in 24 i the Fu pletely	Medical	one)	iner: On the basis of examination and/or in and manner stated.	vestigation, in my	opinion, death occurred at	the time, date	and place, and du	e to the cause(s)
Tot Tot Marith	Σ	29b. Signature and title of certifier	o ()	29c. Licen:		29d.	Pebruar	y 4, 2010
AS		1 Oche	/ MD		046561		1eh.02;	2010
1011		30. Name and address of person who considered (Month, Day, Year) 31. Date filed (Month, Day, Year) FEB 16 20	completed cause of death (Item 23a) (Type,	Print) AGTHA	ROM	HAGO	MUDUN	MD 21740
		-11.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 1146 AM 2010 <u>Lula Almeta Swain</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs, 8. Date of Birth (Month, Day, Year) Feb. 2, 1922 **Funeral** 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Min. Hours 1 - M 2 X F Director 216-14-5659 88 MD Usual Residence of Decedent 28a-f show 10a, State 10b. County "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14104 Roberts Road 21750 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married þ 1 Yes 2 No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Riviter Aircraft Manufacture Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clevelan Tobias Shoemaker Mary Elsie Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Wolfe/Daughter 146 Crest Drive Warfordsburg, PA 17267 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Piney Plains Cemetery 02/17/2010 Little Orleans, MD 21 Signatur of Furreral Service 22. Name and Address of Facility 141 West Main Street MO0266 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) RESPIRATORY INSUFFICIENCY Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events rsician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for 1 in the past 12 months? Month Pregnant at time of death Yes 2- No detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 1 Yes 2. No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2-1 No Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)

DHMH 17 Rev 7/2009

State

Registrar

MOHAMNEO

FEB 25 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed Aziz, M.D. 251 E. Antietam St. Hagerstown, MD 21740

32. Registrar's Signature

D66892

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 4. Physician/ 2010 11:23 AM MELISSA FRANCINE SWANN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs g. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Funeral Months 1 □ M 2 🔽 F SEPTEMBER 30.1966 MARYEAND 219-83-6971 43 Director Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No INDIAN HEAD MARYLAND CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20640 UNITED STATES 3925 CINDY COURT 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) 12TH GRADE nday (0-12) NOT APPLICABLE UNEMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ge 1 and 2 should be fil nt of Health and Mental :: If item 27 is marked CAROLYN FRANCINE JACKSON SWANN STERLING ROSCOE SWANN, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 CINDY COURT, INDIAN HEAD, MARYLAND CAROLYN F. SWANN / MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State Date Department of Hamportant: If ite any injury or other Page 1 a 1 X Burial 2 Cremation 3 Removal from State PLEASANT GROVE CHURCH CEM. FEB. 11, 2010 MARBURY, MARYLAND 4 Donation 5 Other (Specify) no ure of Funeral Service bigensee TRAL HOME, P.A. ON ROAD, INDIAN HEAD, MARYLAND 20640 LADIA C. THORNION JOHNSON 23a. Part 1. Enter the disease, or complications that caused the death, Do not ente shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed that initiated events resulting in death) Last the burialphysician Physician/Medical P.O. Box 68760 attending phase as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No the a 9 Unknown Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes pus BRyTheo mitosis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 24 hours after death. has page 2 autopsy performed death? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 7 100 ၉ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ithin 24 hours after death.

the Funeral Director: A pmpleted filled in by the fu Accident
Suicide Investigation 6 Could 28e. Pluce of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide rmined City or Town, State Medical Certifying Physician: T, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Gledical Examiner: O the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse P corpore. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the P only on 29b. Signatu

BBN 2

State

30. Name and address of person who completed c.

2010

Registrar

of death (Item 23a) (Type, Print)

eBura, 5,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Donald Shorter 2010 /Medical unty of Death Facility Name (If not institution, give street and number) Location of Death **Examiner** ENTER **EDICAL** If Under 24 Hrs. ocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 220-16-8653 85 Director 22,1924 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ▼ No Director Charles MD Bel Alton 10g, Citizen of What Country? 10e. Street and Number 10f Zin Code 9250 Chapel Point Road 20611 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 1 □Yes 2 No White Specify. ۾ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Thomas A. Shorter Lillian Elizabeth Fowler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other troops. Rita Shorter/Wife P.O. Box 205, Bel Alton, MD 20611 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Ignatius Cemetery 2/13/2010 Port Tobacco, MD 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility M00945 AREHART-ECHOLS FUNERAL HOME, P.A. E540 au 20646 Mary s 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 H0 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 4 1√0 Certification: To 1 Thipatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, detached signed I page 2 should Hospital or Attending Physician: funeral director, e Funeral Director; Af eletely filled in by the fur completely

death with the Maryland

Pages 1 and 2 should be filed within 72 hours , fter

Health a

Maryland 21215-0036

Baltimore,

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exar, in a remark to motify of a

within 2 To the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Holly LANE Suite 107 Waldorf MD

29a. Certifier

one)

(Check only

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 050nt 2-20 PO 0200 A Roland Lincoln Still Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death

Bel Air ic. County of Death Haryord **Examiner** Upper Chesapeake Medical Center 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 74 Days Hours 04 M2 7 D - D 9 19 335 MESTERRand 215-34-7256 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director Street Harkord Maryland 1 Yes 2 M No 10f. Zip Code 10g. Citizen of What Country? United States of America 10e Street and Number 21154 Funeral 3323 Dublin Manor Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 X Married Completed by Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service Laborer Be 17. Father's Name (First, Middle, Last)
William Lincoln Still 18, Mother's Name (First, Middle, Maiden Surname) Adelaude Mulier 19a. Informant's Name/Relationship (Type, Print) Helen Still (Wile) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3323 Dublin Manor Road, Street, Maryland 21154 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place, Rock Run Cemetery 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-15-2010 Havre de Grace, Maryland 22. Name and Address of Facility Zeelman Functal Home, P.A. 123 S. Washington St. Havre de Grace, ND 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiogenic Shock Physician/ disease or condition resulting in death) Medical Examiner Pericardial tamponade Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Quality forms on consistences of ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IE FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by muitible myeloma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s performed? Yes 2 No 1 Yes 2 No certificate **Division of Vital** funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 \square No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pendina 2 Accident Investigation I Director: And in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completed filled in Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner To the basis of my knowledge death occurred at the time date and close to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D63420 February 12,2010 and address of person who completed cause of death (Item 23a) (Type, Print) pperChesapeake Dr. Bel Air, MD 21014 m.0.500 U 32. Registrar's Signa ure State 0

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14, 2010 February 11:55 p.[™] TOMIC Ruth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown 11430 Englewood Road 8. Date of Birth (Month, Day, Year) June 24,1921 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 1 F 072-16-7005 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Washington Hagerstown 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21740 11430 Englewood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married white 1 ☐Yes 2X No Specify Specify: Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -0her own home homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be George Miriam Keefe Primm ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21740 Candy Kline - daughter 11430 Englewood Road, Hagerstown, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2010 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 **O** No 9 Unknown 9 🗌 Unknown ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 TYes 22 25230 Be 25. Was case re examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manne of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical xamine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

requires that the death certificate be executed P.O. Division of Vital Records, The law Physician: or Attending ours after death.

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Box 68760,

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

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Hospital within 24 hours To the Funeral

State Registrar

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(Check only one)

29b. Signature and t

30. Name and

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ess of person who

Registrar's Signature

Hegastown

completed cause of death (Item 23a)

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** HildA MAE LURIVER ebruary 3,2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Vear | If Under 24 Hrs. Wicomica Salisbury Rehabilitation & Nursing C 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗵 F Months Days Hours Min ountry 220-28-1013 10-14 Director MARULANIA Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director LISDURU MARYLAND Willmile 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō lictoria 21801 D12. USA "natural", or items 23a Funeral death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 25 Married Maryland 21215-0036 1 Yes 2 No þ Specify Specify: BIAL 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NEWE Dome. stic 07 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NORMAN DASHIE 0 CKERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatth a Important: If Item 27 is any Injury or other trau once. Showe MARINE WALLACE 10 27 2011 Sourcy, Ma 2150 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State YMC. CEM. 2-13-2010 4 Donation 5 Dother (Specify) MARY AND 21. Sign tur or Funeral Service Licenses 22. Name and Address of Facility Md 21801 821 MBJK ELVAR 23a/Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List only one cause on each life Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequence of the case Due to (or as a consequence of) Examiner Hospital or Attending Phyalclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has be director, page 2 s autopsy 2 4No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending investigation illed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Peritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robin S. M. D. 200 (

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death F&BRuary Physician/ 20990 15 AM David Verlon Wright Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Harkord Citizens Care pocial Security Number de Grace Conten Havre 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 01/10/977.953 Min. 57 217-60-4321 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 No Aberdeen Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21001 3300 Churchville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. If Yes, Give Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic
once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Building Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Rottu Jane Stamper Verlan Cleveland Uright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21903 Arch Street. Perruville. Danies Brown (Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/13/2010 Aberdeen, Maryland larkord Mem. Gardens 22. Name and Address of Facility Zellman Funeral Home, P.A. Signature of Funeral Service Licenses Washington Street. Havre de Grace Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onse and Death Immediate Cause (Final epato cellular Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the a tending physician and physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box (in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached is 1 L Yes 2 L Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10-Mic Amend Item 18 per FH G902 4/13/10 dk

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		Atlantic General Hospital	ura last hirth	Berlin day) If Under 1 Yea	ar If Under 24Hrs	8 Date of Birt	Worcester	. Birthplace (State or Foreign
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Baltimore, permit. Pages 1 an Department of He, Important: If ite	0	4 Donation 5 Other Specify:	DENNIS					LLE, MARYLAND
Baltimo permit. Page Department of Important: injury or ott	4	21. Signature of First		MELSON FU.	NERAL SEF	VICES, L'	TD	100/5
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/Medical Examiner	0 7	failure. List only one cause on each line. Immediate Gause (Final disease a. <u>Hypertensiv</u>	ze athe	eroscleorti	c cardiov	ascular	disease	Between Onset and Death
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Division tall or Attending after death. The Director:	Certification:	3 Suicide Could not be	- At home, far	m, street, factory, office	building, etc.	28f. Location (S or Town, St		or Rural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi sely filled in by the funeral director,	Cel	29a. Certifier	vuladaa daat	h occurred at the time.	tate and place, and	due to the cause	e(s) and manner as	stated
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my opinio	n, death occurred a	at the time, date a	and place, and due	to the cause(s)
5 ½ ½ §	Me	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
		Myll X M.	7	O.C	.M.E.		February 17,	2010
		30. Name and a dress of person who concleted clause of death		111 Penn Street	Raltimore M	D 21201		
	tata	Russell Alexander MD Assistant Medical E 31. Date filed (Month, Day Year) 32. Registrar's Si			., Daithille, M	D Z 1ZU1		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 1atthew Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Medical Cente Vicamico salisbury 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min (Month, Day, Country) Director irginio Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at Director Hebron 1 Yes 2 No Vary land Wicomico 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates. , o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural" 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) aul Be 17. Father's Name (First, Middle, Last) perunt, Page 1 and 2 should be file
Department of Health and Mental H
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any injury or All 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheil 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 15, 2010 5 Other (Specify) 21. Signature of Jun ral Service Licensee Funera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ 45(VI) disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ESRD Sequentially list conditions, if any, leading commediate cause. Enter Underlying Cause (Disease or linjury Dus to (or as a consequence of, and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed TB that initiated events Due to (or as a consequence of): resulting in death) Last physician as the burial Physician/Medical P.O. Box 68760 as been signed by the attending p 2 should be detached for use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed Yes 2 No death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MS 21804 5. DIVISION Shew 1415 NATESAN

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3 per phys G900 2/25/10 dk State of Maryland/ Bepartment of Health and Mental Hygiene 0552 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** P^{M} Fannie J. Yoder Feb 18 2010 6:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1447 Dorsey Hote1 Rd Grantsville
If Under 1 Year | If Under 24 Hrs. Garrett 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stat Country) May 27,1926 Maryand 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 220-40-1426 83 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director MD Garrett 1 □Yes 2 □ No Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 1447 Dorsey Hotel Rd 15536 Funeral USA death items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ ★o Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite 1 ★ Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be U. Yoder John Mary Kinsinger ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health &
Important: If item 27 is
any injury or other traus Albert R. Yoder 1447 Dorsey Hotel Rd Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Niverton Amish Ceme Salisbury, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 203 North St. M. Ray Leckemby Funeral Home Meyersdale, Pa 15552 m Ray 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Drain Metastase disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 □Yes 2 □No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after uc...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO D D0634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 Bissell Miller Grantsville, MDXx 21536

DHMH 17 Rev 1/2001

State

Registrar

Robin

31. Date filed (Month, Day, Year)

EB 25

ORIGINAL

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 10:27 P M Mary Lou Alrey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Nov. 5, 1930 Michigan Director 79 385-28-6232 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3329 Sea Port Way 20902 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Civil Servant City of Detroit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elzie Revnolds Jessie Cash other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 3329 Sea Port Way, Silver Spring, MD 20902 Sanita Debose (Daughter) Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State De cenetery cramatory of the Place) Donation 5 Other (Specify 2/26/10 Park East Warren, MI 21. Signature of Funeral Service Licenses ²² Name and Address of Facility James Cole Funeral Home 2624 W. Grand Blvd., Detroit, MI 48208 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 Weeks Immediate Cause (Final Physician/ a. Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) transit Exam Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam.
9 ☐ Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? signed I þ Congestive Heart Failure, Osteomyelitis of Pelvic Bones 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Adult Failure to Thrive has autopsy performed? Yes 2 X No page 2 this certificate 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ី No 1 Yes ဂ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending n 24 hours after death.

Funeral Director: A pleted filled in by the fu death. 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29c, License number 29d, Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

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Nurul Chowdry, M.D.

FEB 26 2010

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43121

15216 Dino Dr., Burtonsville, MD 20866

February 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1900 2010 Allen February 16, Warren /Medical Ronald 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Cheverly Prince George's Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 5, 1944 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 💢 M 2 🗆 F Salisbury. Dec 65 246-68-3466 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examiner most be notified at 1 X Yes 2 ☐ No NC Salisbury Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 28144 USA 470 Nestlewood Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1965 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 🛣 No If Yes, Give Year or Dates: Specify. Specify: White 2 3 Widowed 4 Divorced 1967 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. US Government Health Education Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ola Mae Smith William Henry Allen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) or other tra 470 Nestlewood Lane Salisbury, NC 28144 (Sister) Martha Allen 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. 2-22-10 Salisbury, NC US National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Summerset Funeral Home 22. Name and Address of Facility e of Funeral Service Licenses Salisbury, NC 28144 1315 W. Innes St. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Out to (or and consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □Yes 2 □ No Day 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 2 No 1 ☐ Yes director. 25. Was case referred to medical examiner?
12 Yes 2 □ No Be 26. Place of Death (Check only o e) Hospital: Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this filled in by the funeral 27 Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 24 hours after death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

4 Homicide 29a. Certifier Medical (Check only To the within 2.

State Registrar 29b. Signature and title of certifier

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr., Cheverly, MD 20785 M.D. James Catevenis,

31. Date filed (Month, Day, Year,

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ademilu 12:50 PM tlaba 2010 Februar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore DWSDY 9. Birthplace (State or Foreign Country) Nigeria If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F (Month, Day, Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No winas Of. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3104 Walnut venue 21117 Nigeria 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Specify: NIGOIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ_NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Education Principa permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lsaiah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) venue Uwings Mills MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Lagos, Nigeria 04/09/10 Voutts & Gardens Cemetery 4 Donation 5 Other (Specify) Vaughn C. Greene Fanera services 21. Signature of Funeral Service Licensee Randallstown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 150/114 Cerebellopont Immediate Cause (Final Onset and Death Physician/ months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical 68760 To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physocompleted filled in by the funeral director, page 2 should be detached for use as the loampleted filled in by the funeral director, page 2 should be detached for use as the loampleted filled in by the funeral director, page 2 should be detached for use as the loampleted filled in by the funeral director. IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Box Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 2 XN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ADSM12411 2 X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R149194 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 TOUSUA MD Grant 31. Date filed (Month, Day, Year) . Registrar's Signatu State FEB 26 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 20 2010 Walter Dormitzer Abbott, Jr. 11:45 PM Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Massachusetts 1 **K** M 2 □ F Months Hours Min. March 2,1939 70 002-28-9759 Director Usual Residence of Decedent or items 23a or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 X No Ellicott City Maryland Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 2914 Eaton Square Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces'
1 Yes 2 If Yes, Give Proces : No Army Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Department of Defense Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Lila Mignaun Walter Dormitzer Abbott, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2914 Eaton Square Ellicott City, Maryland 21043 Regina Abbott (Wife) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Columbia Memorial Park 2-26-2010 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Witzke Funeral Homes, 5555 Twin KNolls Road Signature of Funeral Service Licens Inc. Columbia, MD 21045 23a. art 1. Enter the rise us, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fill e. List only one cause on each list. Approximate Interval Between Onset and Death Immediate Cause (Final Ancec Physician/ nonth disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Month Year Day Yes 2 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Division of Vital Records. 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1_ Natural 5 Pending 2 Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier Henraw (18) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February 24, Physician/ Asquith Harriet 2010 8:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill Nursing Center Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 13, 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex **Funeral** Year) 914 Days Hours 1 □ M 2 尿 F Canada 95 Director 084-14-0395 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5215 W. Cedar Lane 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Condominium Company Assistant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be file Health and Mental H Item 27 is marked of ဂ George Askwith Mai Dalglish Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dietrich A. Dollak / Son 501 Slaters Lane #804, Alexandria VA 22314-1117 permit. Page 1 and 2.
Department of Health
Important: If item 27
any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory ! 2/25/2010 Beltsville, MD Signature of Funeral Service to 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Ent r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Heart Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any leading to humostate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) Carotid Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Dimentia 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Congestive Heart Failure neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No Hospital or Attending Physician: The | 24 hours after death. this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4XXNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

only one)

29b. Signature and title of certifier

nomy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOSLANGE

32. Regis ar's Signature

Thomas V. Joseph M.D.; 5000 Edmonstron Dr. #207, Rockville, MD

29c, License number

D0047330

29d. Date signed (Month. Day, Year)

February 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AM Februar Physician/ Medical 4a. Facility Name (if not institution, give stre 4c. County of Deat Examiner 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F Months **Director** 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Ses 2 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ö Funeral items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 1. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 ☐ Married ō þ Maryland 21215-0036 1 Yes 2 No Specify: "natural", If Yes Give 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, #102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla 2010 4 Donation 5 Other (Specify) 21. Signatura f Funeral Service Licenses 22. Name and Address of Facility mera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ he a be hic Colon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed and tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death
Unknown 1 ☐ Yes 2 🔀 No 9 ☐ Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has been modeled filled in by the funeral director, page 2: autopsy performed? Yes 2 N 2 🗌 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1X Natural 1 Tyes 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D43386 2.25-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) toward 4405 Rulh nort 21201 (N)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3130 PM 2010 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** a843 Baltimore W. Garrison venue Social Security Number 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-20-1958 Nev. 25 1 M 2 □ F Months Country) **Director** Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho; any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD1 ¥ Yes 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA **s**arrison 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working steel Worker (Specify only highest grade completed) onday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) brown 19a Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. thre., moson Baltimore, od of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Cosville 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Servicus Balte. 23a. Part 1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each live Interval Between Onset and Death Immediate Cause (Final Physician/ 30 minules disease or condition resulting in death) Medical Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 /es, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform this certificate 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 1 No Other: Certificate: To 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at work? To the Funeral Director, After completed filled in by the funer 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) HAKOR, MD 4W. ROLLING CROSSROADS, CATONSVILLE MO 21228 RUCHIRA

Registrar

State

31. Date filed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Patricia Aronica-Pollak MD.

26

29b Signature and title of certifier

32. Registrar's Signature **ORIGINAL**

Assistant Medical Examiner

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 22, 2010

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

30 Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 24, 2010 11:27P M ROSALEEN BUCHTA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Dove House Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XX Hours 0ct 27 1926 151-28-2250 83 I re l'and Director Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo Maryland Carroll Finksburg 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 1794 Brookshire Court 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2XX No 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Patrick Halton Margaret Mary Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1794 Brookshire Court Finksburg Maryland 21048 19a. Informant's Name/Relationship (Type, Print) Sonja A Uveges DTR Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🗱 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Maryland Moreland Memorial Pk ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FaMYtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 nature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MIS Medical resulting in death) Examiner E sque than list con ultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔽 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier H0061206 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Tracie Ryberg MD 688C

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar's Signature

Poole Road Westminster Maryland 21157

		1 - For State Of Maryland Registrar		icate of D			Reg. No.2	LO. 0553L
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give street and number)	1	. City, Town, or Lo	continue of Dooth	2. Date of Dea Month	Day 4c. County	Year 19:54M
Examir	ner	720 Rainbow Court	E	Edgewood			Harfor	
Funeral Director		5 Social Security Number 036-16-4423 6. Sex 1 □ M 2 ☑ F 86			f Under 24 Hrs. Hours Min.	8. Date of Birt <i>Month, Dat</i> 5/3/192	'A ^{Year)}	9. Birthplace (State or Foreign Country) Massachusett
e Maryland 8a-f show	ector	MD Harford Edg	Town or Locatio					10d. Inside City Limits 1 □Yes 2 ☑ No
3a or 2	al Dire	10e. Street and Number 720 Rainbow Court	10	of. Zip Code 21040			10g. Citizen of W USA	/hat Country?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. "natural", or items 23a or 28a-f show ont, it a Medical Examinat De notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X/es 2 □ No If Yes, Give Year or Dates: WWII			panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify.	e - American Indian, k, White, etc. White
Maryland 21215-0036 nd 2 should be filed within 72 hours aft alth and Mental Hygiene. "natural", or 27 is marked other than "natural", or traumatic event, it at the field Evert	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's (Give kind life. DO N Hairdre	esser	ring most of worki		16b. Kind of Bu	n
aryland 2 should be filed v and Mental Hygis marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Samuel Morein				ptan		· · · · · · · · · · · · · · · · · · ·
Maryla nd 2 should alth and Mer 27 is marke			•	·	d Number or Run .n Blvd #			State, Zip Code) h, FL 33480
Baltimore, I bermit. Pages 1 and Department of Health Important: If item 2 any injury or other pure.		20a. Method of Disposition 20b. Plac	ce of Disposition netery, cremator 1 top Sei	n (Name of ry or other place) rv. Corp	2/24/	² 2010	Towson,	City or Town, State Maryland
Baltimo permit. Pag Department Important: I any injury o		21. Signature of Euneral Service Licensee	22. Nai Ruci	me and Address K Towson	of Facility To Funera	wson, N Home,	laryland nc. 105	21204 O york Road
Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ve Hi	e mode of dying,	Failu	or respiratory ar	rest,	Approximate Interval Between Onset and Death 3 weeks
68760, rificate be executed ng physician and as the burial-transit	Medical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Demer Due to (or as a consequent)	rtia	, Alz	heim	ers	type	5 years
I Records, P.O. Box The law requires that the death cer ate has been signed by the attendin age 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ect	opic pregnancy ner (specify)			23d. Date Mor	e of delivery nth Day Year
cords, P.O. w requires that the de been signed by the a should be detached	ğ	Part II. Other significant conditions contributing to death but not resulting	ng in the underly	ying cause given	in Part I.			ribute to the cause of death? 3 Probably 4 □ Unknown
- 23	Completed					24a. Was autop perfor 1 □ Yes	sy p	Were autopsy findings available prior to completion of cause of leath? I □Yes 2 □ No
of Vita Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	3/Outpatient 3	Othor	6. Place of Deatl		<i>ne)</i> lence 6 □Othe	er (Specify)
vision of Vita Attending Physician: or death. ector: After this certific by the funeral director,	Certification: T	Matural 5 ☐ Pending (Month, Day, Year) investigation	8b. Time of Injury	28c. Injury a Work? И 1 □ Ye			ow injury occurre	
Divis	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, f	actory, office		28f. Location <i>(S</i> City or Tow	Street and Numbern, State)	er or Rural Route Number,
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and manner stated.	edge, death occ n and/or investi	curred at the time gation, in my opir	e, date and place, nion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	inner as stated. and due to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier Mark D. Heusen	m	29c. License r			,	(Month, Day, Year)
2th		30. Name and address of person who completed cause of death (Item 2:	3a) (Type, Print)	Balt	1more	, mr		201
Sta Registr DHMH 17 Rev 1/2	ar	31. Day EBM2'602010 Seneral 32. Registrates Signature	tille					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 22, 9:35 P M 2010 TRVIN **JEROME** CLANCY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air 2515 Cool Spring Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 17, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Yrs 1920 Maryland 218-01-6192 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 0a. State 10b. County nem z/ is marked other than "natural", or Itams 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Harford Bel Air 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21014 265 Wakely Terrace 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritaf Status Bfack, White, etc. within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: þ 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) permit. Pages 1 end 2 should be tiled wit Department of Health and Mental Hygiens Important: If liem 27 is marked other that any ijury or other traumatic avent, ITAL 90038. Civil Service 11 <u> Heavy Equipment Mechanic</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Virgil (nmn) Clancy Ruth Estelle Rambo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janice A. Spellman/Daughter 2515 Cool Spring Rd., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 2-26-10 Baltimore, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility McComas Funeral Home P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 A caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and a cardiac or respiratory arrest, and a cardiac or respiratory arrest. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications shock, or heart failure. List only one cause ions t fmmediate Cause (Final disease or condition resulting in death) **Physician** ONGESTIVE HEART /Medical Due to (or as a consequence of): Examiner EMPHYSEMA Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physicien and hed for use as the burial-transit CORONARY Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cete has been signed by the ette , page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has performed? Yes 2 2 No 2 🗆 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Daughter's 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Residence To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D415921 rounder FEARUARY 23, 2010 MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED 2227 OLD EMMORTON RO MAHMOOD 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** If Under 1 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Security Number **Funeral** Months 1569 Days 1 □ M 2 🗹 F **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐Yes 2 No the Medical Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Items 23a 2/2 Completed by Funeral Was Decedent Ever in U.S Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 "natural", or 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry LTIMORE COUNTY nd Mental Hygiene. marked other than Elementary/Şecondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 Is marked other ti jury or other traumatic event, Its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he are failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Box 68760. IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1€ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No certificate 2XNo of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 102 Natural 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation ours after death. Ieral Director: Af filled in by the fur 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C the Hospital 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and Me of certifier 30. Name and address of person who completed cau

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 01:51 PM Sandra Therese Cucchiella CORUGRU 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical TOWSON Baitmore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 🛣 61 Washington, DC 216-52-7991 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Nottingham 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 36 Sylvan Park Court 21236 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Securities Officer M&T Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances T. Trinite Louis G. Forte, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a Gina Cucchiella - Dauchter 36 Sylvan Park Court, Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or Dulaney Valley Manorial
Cambris 1 XBurial 2 Cremation 3 Removal from State March 2,2010 4 Donation 5 Other (Specify) Timonium, Maryland 22. Name and Address of Facility
Evans Fureral Chapel & Cremation Services - Parkville 21. Signature of Funeral Service Licensee 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CPS15 Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine **YMPHOMA** as the burial-transit attending physician and that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s performed 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date stoned (Mont . Day. Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON OSIER DRIVE

State Registrar 7601

M.D

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31. Date filed (Month, Day, Year)

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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shoul ind M mar	ř	19a. Informant's Nam	ne/Relationshi	p (Type. Print)			19b. Mailin	ng Address (Street	and Number or F	tural Route Numi	ber, City o	r Town, State, 2	Zip Code)	
and 2 allth a 27 is er tra		Beth Summe	rs (Ni	ece)		Ì	700 T	Wyngate I	r., Fred	lerick,	MD 21	1701		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Example.		20a. Method of Dispo		B ☐ Removal from S	toto	20b. Pla	ce of Disponetery, cren	sition (Name of natory or other place	ce)	Date	20c. Lo	ocation - City or	Town, State	
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	Medical C	29a. Certifier 1 (Check only 2 one)	☑ Certifying ☐ Medical E	Physician: To the la kaminer: On the ba and mann	sis of	examination	edge, death on and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s) , date and) and manner as I place, and due	s stated. e to the cause(s)	
To the within To the Comp	Me	29b. Signature and titl	le of certifier	san/	17	7	M	29c. Licens	e number		29d. Dat	te signed (Mont	h, Day, Year)	
SV		30. Name and addres	s of person w	no completed cause	of de	eath (Item 2	23a) (Type, I	Print)	120			7/2	110	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-01511 State of Maryland / Department of Health and Mental Hygiene 2010 05536 Venita R Crawford 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last), Physician/ Month Day February 19, 2010 1738 hrs dical Examiner 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3903 Marx Avenue Apt. 2 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Hours Months Davs Director Country) 2 **V**F 1 M Usual Residence of Decedent 10d Inside City Limits Ioc. City, Town or Location Ξž 1 Yes 2 No the Medical Examiner must be notified at once, hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e Street and Number USA 21206 Race - American Indian, Black, White, etc. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Yes Yes 2 No specify: Divorced If Yes, Give Year ģ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) es 1 and 2 should be filed within 72 to 6 of Health and Mental Hygiene. Assistant Yurses it: If item 27 is marked other other traumatic event, the Mo 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a Informant's Name/Relationship (Type, Print) Street 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Removal from State 1 V Burial 2 Cremation 3 Donation 5 Other Specify 22 Name and Address of Facility 21. Signature of Funeral servi e Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir Physician Between Onset and failure. List only one cause on each line. Death /Medical a Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical AMENDED 23a, 27, 28a-f, permE, X UNPENDED attending physician for use as the burial g901 3/8/10 TT Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. reate has been signed by page 2 should be detached ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Vital æ Other: Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 V Yes 28d. Describe how injury occurred 5 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Natural 1 Yes 2 X No Pending Fd 2/19/10 Fd 5:30 pm 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 26f. Location (Street and Number or Rural Route Number, City or Town, State) 3903 Marx Ave 3 Could not be Suicide determined within 24 hours a To the Funeral I <u>Baltimore</u> Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier February 20, 2010 O.C.M.E. Willowa 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day Year FEB 2 6 2010 32. Registrar's Signatur

Margarita Korell MD.

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** James E. Daley 20/0 /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Examiner** ose Himore Mare 24 Hrs Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number rs. last birthday) Age (In **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 217-34-6727 71 MD 3,1938 Director June Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show Exacting count be notified at MD Baltimore 1 ☐ Yes 2 No Director Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1001 Middlesex Road items 23a 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married P. 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced n and Mental Hygiene. Completed Department of Health and Mental Hygiene, important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical page. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Indusco Group 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul H. Daley MAry A. Poole မ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Daley /wife 1001 Middlesex Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 2/26/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signatured Funeral Service Licensee 22. Name and Address of Facility 300 Mace Balto. MD Connelly Funeral Home 21221 23a. Part 1. Enter the disease, or complications that caused he shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or 1/ a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) s been signed by the should be detached 1 □Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 standard autopsy performed? 1 □ Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending Injury 124 hours after death.
 E Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho To the Fune completely f (Check only one)

State Registra

29b. Signature and title of cept

BINH NGUYER

29d. Date signed (Month, Day, Year)

30. Name and address of person who compl ed cause of death (Item 23a) (Type, Print)

9000

32. Registrar's Signature 31. Date filed (Month, Day, Year) EB 26

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per Phy G900 2/26/2010 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 7 2. Date of Death 02-19-2010 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 343 AM 1 HOMAS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 70 Months Days Hours Min. 12Mo2t8 Day 939 Country) Director MD 219-36-0558 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No MD Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral items 23a USA 21015 300 Hazelnut Ct #C Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) Gollege (1-4 or 5+) Dept. of Army Graphic Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William E. Doxzen Delia Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Hazelnut Ct #C Bel Air, MD 21015 (Wife) Elsie M. Doxzen 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place
Bayview Crematory 1 Durial 2 X Cremation 3 Removal from State 02-22-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Inc 610 W. MacPhail Rd BelAir, MD 21. Signature of Funeral Service Licenses Home of BelAir 21015 Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of dead line. Interval Between Onset and Death Immediate Cause (Final Dreumonia iration Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to or as a cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Year Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕱 No Other: ၉ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending e nove in 24 hours after over the Funeral Director: Aft 'siled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2556

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State Registrar	State of	of Maryla		partme ertifica				lental Hy	giene Reg. No	2011)	05539
		Physici		1. Decedent's Name (First, Middle Doris S. Day	e, Last) 'ison			\				2. Date of De Month Februa	ath Da		r	3. Time of Death 9:15 PM
		/Medio Examin		4a. Facility Name (If not institution Glen Meadows	n, give street and nu	mber)			y, Town, or en Ar		of Death		40	Baltim	ath	
		Funeral Director		5. Social Security Number 214-18-7513	6. Sex 1 ☐ M 2 ☑ F	7. Age (In)	Yrs. last birthd	Month	ler 1 Year s Days	If Unde Hours	Min.	8. Date of Bir (Month, Da 8/1/1	th ay, Year, 920	9. B	Country	e (State or Foreign and
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21		deeth with the Maryland ms 23s or 28e-1 ehow	ector	MD Baltin	ore	G	len Arn		Zip Code				10a. Ci	itizen of What	Country	1 ☐ Yes 2X No
0		h with	DIE	11630 Glen Arm	Road G-	14			1057				US		,	
05/25/2010		permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Proportant: If them 27 is marked other than "natural; or Itema 23a or 28e-1 show eny injury or other traumatic event, the Madical Examinar must be radified at ODGE.	d by Funeral Director	11. Marital Status 1 Never Married	12. Was Dec Armed For ned 1 Tyes If Yes Gi	2 X No ive	n U.S.		cedent of Hoecify Cuba	lispanic O an, Mexica Specify		ecify Yes or No Rican, etc.)		14. Race - Ar Black, Wl Specify:	white, etc	te
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40 150N		alth and 27 le m		19a. Informant's Name/Relations Wilmer Davison				-				ai Route Numb L4 G1e	-			
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Poris	Balti	permit. Depertm Importa eny inju		21. Signature of Funeral Service	Licensee (M	in	22. Name Ruck				owson, I Home,				
		Cate be executed / Medical Examiner street be privately transit street burial-transit	al Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Frac Due to b. Due to c.	(or as a con	1-0	+ fe	ode of dyin		s cardiac	or respiratory a	irrest,		In	pproximate terms the state of t
		To the Hospital or Attending Physicien: The law requires that the death certificate within the Arbous efter death. On the Puneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the temperal process.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 ☐ F nant at time	etal death	3 □Ectopic 5 □ Other		,			1	23d. Date of o	delivery	ay Year
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	Z.	sicier certif irecto	o Be	25. Was case referred to medical examiner? 1. Yes 2 □ No	Hospital:	Inpatient	2 🗌 ER/Outpa	tient 3	DOA Oth	or	21200000	h <i>Check only</i> ome 5 ☐ Res	-07	6 Other (S	20061	1100
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		OA Sompti	M	29b. Signature and title of certified 30. Name and address of person	the Mit	Du se of death) (Ty	pe, Print)	29c. Licens	66	7		,	ate signed (Mo		ZOIO
		Sta		31. Date filed Worth, Day, Year	e 110, M 1	Registra s S	ignarire sall	1eH	MCT	Lut	heri	ille	Ma	1 210	93	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** otoma c e gomer If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace State or Foreign **Funeral** (Month, Day, 1 X M 2 🗆 F Months Days Min. Yea Country) 227-22-1969 83 Director ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, a many injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be Funeral 200 12. Was Decedent Ever in U.S. Armed Forces? 1 ★es 2 □ No N ↔ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 ttorne/ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shington, DC N.W. varen 33 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature Free Service Lion 22. Name and Address of Ticility Dr. Jessudi PA Midvalla 1232 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Physician MIGNIC disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last -pnialattending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ with pul minary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural injury work? 5 Pending fter decth. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours

To the Funeral 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Arnua

9861

32. Registrar's Signature

nitha Bhogavilli

31. Date filed (Month, Day, Year)

Silverspring

MO 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Ellis		State of Maryland / Department of Hea 1- For State Certificate of Dea			201	0 0554
Physicia Medical Exami	m/	Registrar 1. Decedent's Name (First, Middle,Last) Robert Ellis		2. Date of Deat Month February 1		3. Time of Death 1450 hrs
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under the Security Number 6. Sex 7. Age (In yrs. last birthday) Mont	der 1 Year If Under 24Hr ths Days Hours Min		th(MM/DD/YYYY) 9. B Fore	
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	/ Funeral	1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	ify Cuban, Mexican, Puerto $2^{ ilde{X}}$ No specify:	o Rican, etc.)	White, etc.	Thite
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2121: hould be fill and Mental E is marked tite event,	To Be	Robert L. Ellis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	ESEN S (Street and Number or	er Bewle	-	te, Zip Code)
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donetion 5 Other Specify: 20b. Place of Disposition (Na Miscrements of Disposition) 20c. Crownsviille	me of cemetery,	Date	20c. Location - City of	
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detace	۲	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?		now injury occurred	
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Divisi To the Hospital or At within 24 hours after of To the Funeral Direct	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.				
To with	ğ		c. License number		29d. Date signed (M	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	-	February 21, 20	110
411		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Stre	et, Baltimore, MD 2	1201		
Sta Regist	ate rar	31. Date filed (Month Par 18 26 2010) 32. Figistrar's Signature . Jane	g			
	_					

OCME 2006

10-01567 James Entwhistle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			Certifica	te of L	Death			R	eg. No.	
Physicia	Registrar 2. Date of Death Month Day Year								3. Time of Death	
ical Examir		James E	ntwhist	tle				February	21, 2010	1809 hrs
		4a. Facility Name (if not institution, give street and number)		4b.	City, Town, or	Location of	Death		4c. County of D	
		2603 Page Drive			Dundalk				Baltimore	, , , , , , , , , , , , , , , , , , , ,
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birth	day)	If Under 1 Yes			8. Date of Bi	th(MM/DD/YYYY)	Birthplace (State or oreign
Director	ı	217-40-7807 1 X M 2 F	67	Yrs.	Months Day	s Hours	Min.	.Tanırar	y 4 , 1943	Country) Maryland
	L	Usual Residence of Decedent						DOLLAR	, 1,,,10	
any			City, Town o	r Location	1					10d. Inside City Limits
		Maryland Baltimore		Dun	ndalk					1 Yes 2 X No
Aaryland 28a-f show 1 at once,	ğ	10e. Street and Number			10f. Zip Code				0g. Citizen of What	Country?
r 28	ē			1	212	22			USA	
th the 23a c	_ L	2603 Page Drive 11. Marital Status 12. Was Decedent Eve	rinlls	13 Was I	∠ ! ∠ Decedent of Hi		n? (Spec	cify Yes or No		American Indian, Black,
th wi	uner	1 Never Married 2 Married Armed Forces?			, specify Cuba				White, e	etc.
or dea	쾺	1 Yes 2 X 3 Widowed 4 X Divorced If Yes, Give Year	No	1□ Y	es 2 X No	specify:			Specify: W	hite
s afte	۵	15. Decedent's Education (Specify only highest grade complete	ted) 16a. D		Usual Occupa		ind of wo	rk done	16b. Kind of Busin	ness/Industry
"natı	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	<u> </u>	luring mos	t of working life	e. DO NOT u	use retired	d)		
36 iin 72 han dical	e	12 years		Mec	hanic				Auto	
With With	duo	17. Father's Name (First, Middle, Last)				18.Mother's	s Name (F	irst, Middle,	Maiden Surname)	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	$^{\circ}$	James A. Entwistle				Myrt	le He	egert		
212 Ment Ment mark	밀	19a, Informant's Name/Relationship (Type, Print)	19b	. Mailing A	Address (Stre	et and Numi	ber or Ru	ral Route Nu	mber, City or Town,	State, Zip Code)
MD 2 d 2 shou lth and l n 27 is 1	\vdash	Elizabeth Ulrich sister	19	914 R	obinwoo	nd Roa	d, D	undalk	,Maryland	21222
and 2 and 2 ealth tem 2		20a. Method of Disposition			on (Name of c	emetery,	Eob.	Date	20c. Location - C	ity or Town, State
Ore ges 1 ges 1 rof H		1 Burial 2 X Cremation 3 Removal from State	Bayvi	ory or other	remato:	У		ruary 2010	Raltimo	re, Maryland
timent rtant	- 1	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee		22 Na	me and Addre	s of Facility	<u>-</u> _			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		24 Signature of Funeral Service Littersee		Con	nelly I	unerá	l Ho	me Of	Dundalk,P Dundalk,M	D. 21222
		23. P.M. Enter the disease, or comil calions that caused the	death. Do no	t enter the	mode of dying	, such as ca	ardiac or r	respiratory ar	rest, shock, or heart	Approximate Interval
Physician /Medical	- 1	Milure, List only one cause on each line.								Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Ca		ar Dise	ase					
		h	51100 01).							
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions).	ence of):							
	盲	cause. Enter Underlying Cause (Disease or injury that initiated								
Si e di	Examine	events resulting in death) Last Due to (or as a consequ	ence of):							
recuted and ransit		d								
'60, sate be execution physician and he burial - trans	Medical	UNPENDED							23d. Date of de	elivery
76(ficate		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of the line		Feta	al death 3	Ectopic	pregnan	су	Month	Day Year
ox 68 eath certifi a attending for use as 1	iai	past 12 months? 4 Pregnant at tim	e of death 5		er (Specify)					
Box 687 e death certific the attending	Physician/	1 Yes 2 No 9 Unknown g Unknown								
that the d the the d detached		Part II. Other significant conditions contributing to death be	ut not resulting	g in the un	derlying cause	given in Pa	rt I.			ute to the cause of death?
, P.O. res that the signed by be detac	Completed by	Asthma						1Y		Probably 4 V Unknown
ords, aw requir nas been s	etec							24a. Wa	s an 24b We	ere autopsy findings available or to completion of cause of
COF law I has b	n d					-		per		ath? Yes 2 No
tal Rec	Ö				ae Die	ce of Death	(Chack o	-	2 110	
cian:	Be	25. Was case referred to medical examiner? Hospital: Inpatient	2 T 5B/O	utpatient		Tou .		Home 5	Residence 6	Other: Scene
Division of Vital Records, tal or attending Physician: The law requirers after death. The Director: After this certificate has been silted in by the funeral director, page 2 should be an early attential the control of the funeral director.	2	1 Yes 2 No I inpatient 27. Manner of Death 28a. Date of Injury		Time of In		jury at Work			e how injury occurred	
n of \ding Phy. After ti	:uo	(Month, Day, Year		7 II. 110 O. II.		Yes 2	. 1			
isior Attend ar death rector: by the	ati	2 Accident Investigation 28e. Place of Injur	A 5	atraci		,		28f Location	(Street and Number	or Rural Route Number, City
ivis lor A after Dire	Ę	3 Suicide Could not be	y - At Home, is	ailli, street	t, ractory, cinic	, panding, a		or Town		
12 e 15	Certification:	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my k		-45	and at the time	date and ri	200 000	due to the co	use(s) and manner a	as stated.
To the Hos within 24 h To the Fur	g	(Check only one) 2	nowledge, de: nation and/or i	ath occurr investigati	ed at the time, on, in my opini	on, death oc	curred at	the time, da	e and place, and du	e to the cause(s)
To the I within 2 To the I complet	Medical	and manner stated.				nse number				d (Month, Day, Year)
	2	29b. Signature and title of certifier				C.M.E.			February 24	, 2010
		Men Grandy, 1110					_			
\		30. Name and address of person who completed cause of dea		111 D	enn Street,	Raltimor	e MD	21201		
١		Melissa Brassell, MD Assistant Medical E				Daimillo	C, NID 2			
S Regis	tate		Signature	1	arkal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ļ	For State Registrar	State of N	Marylan		artment of H		nd Mental Hy	giene		05543
Ì	Physici		Decedent's Name (First, Middle, Mary	Last) Elizabeth		Eva	ns		2. Date of D. Month Febru	eath Day	Vear	3. Time of Death 9:15 A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numbe	ər)		4b. City, Town, o	r Location of			County of Death	
			Woodside Genes					er Spr			Montgo	
L	Funeral Director		579-14-4772	6. Sex 7. / 1 ☐ M 2X☐ F	Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. 8. Date of Bi (Month, D) Feb • 1	o, 192	Col	nplace (State or Foreign unitry) nington D.C.
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. fnside City Limits
	a-f sh	ctor	MD Montg	omery			Si	llver	Spring			1 ☐ Yes 2X No
	vith the	Director	10e. Street and Number				10f. Zip Code			_	zen of What Co	
	eath v	erai	2308 Kimball P	12. Was Deceder	nt Ever in U	S. 13.1		20910	nin? (Specify Yes or N		nited St	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. The Medical Enarth at traumatic avant. The Medical Enarth at traumatic and DDCs.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ②Divorced	Armed Force	s? ∐No	1	f Yes, specify Cub 1 ☐ Yes 2 况 No		gin? (Specify Yes or N , Puerto Rican, etc.)		Black, White	
20	72 ho	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during most	of working	16b. Kir	nd of Business/I	Industry
121	within and the within	idmo	Elementary/Secondary (0-12)	College (1-4o	or 5+)		<i>DO NOT u</i> se <i>retir</i> e memaker	d)			Own Hor	m e
d 2	Hygir other ant. I	Be Co	17. Father's Name (First, Middle, L	ast)		110	memaker	18. Mothe	r's Name (First, Middle	, Maiden		
/lan	wild be Mental srked	To B	Franklin	E.	La	mpkin		Et	hel Ma	ureer	n (U1	nknown)
Maryland 21215-0036	and I sho		19a. Informant's Name/Relationshi			4			r or Rural Route Numb Huntingto			
ē,	Health		20a. Method of Disposition		20b. F		sition (Name of matory or other pla		Date		cation - City or	
ē	Pages lent of nt: If i	1	1 ☐ Burial 2XXCremation : 1 ☐ Donation 5 ☐ Other (Sp.	3 □Removal from Sta ecify)	ie		hatory or other pla ke Crema:	۱ م	/24/2010	Ве	eltsvil	le, MD
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service &	General January	m0038	2 22 R	Name and Address App Fune:	ess of Facility	d Crematic Silver Spr	n Sei	rvices MD 20	0910
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caus	ed the deat					-	113	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ aA	thero	sclero	tic Dise	ase				Onset and Death
	/Medical Examiner		resulting in death)		as a conseq		eart Fai	1,,,,,				
		Jer	Saguartismy list conditions if any, leading to immediate	D	as a conseq		eart rai.	rure				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C		ension						
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a	as a conseq	uence of):					Ī	
687	physics the k	adica		d								
.O. Box (ne death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у		2	23d. Date of deli Month	ivery Day Year
۵.	res that the de igned by the be detached	by Ph	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
rds	w requires been sign should be	ed b	Atrial Fib	rillation,	Diab	etes		<u> </u>	1	Yes 2]	DNo 3□Pro	obably 4X Unknown
Vital Records,	has has	Completed	Emphysema,	Recurrent	Pu1m	onary	Embolism		24a. Wa auto per 1 🗆 Yes	s an opsy formed? 2000	death?	topsy findings available completion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hamital			24		of Death (Check only			- 137
of	ys Sissip	: To	1 Tyes No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of Ir		ER/Outpatier 28b. Time of	IL SULLOA	100	rsing Home 5 Res			cify)
ion	Attanding Physician: r death. actor: After this certific by the funeral director,	ation	1 Natural 5 Pending 2 Accident investiga	(Month, I	Day Year)	Injury	Wo	rk? ∣Yes 2 🔲 ۱			,	
Division	in Lin	Certification;	3 Suicide 6 Could no determine	and 288. Place of	fnjury - At he etc. <i>(Specif</i>	ome, farm, str	eet, factory, office			(Street and own, State)		ıral Route Number,
	e Hospitat or 124 hours afte a Funerel Dir letely filled in	edical (Physician: To the be xaminer: On the basis and manner	of examina							
	To the landthin 2. To the landthin 2.	Me	29b. Signature and title of certifier	`0			29c. Licen:			29d. Date	te signed (Month	h, Day, Year)
			J-am				D65	301		2	123/20	00
			30. Name and address of person was Farzana Ajmal,					or Snr	ring MD	20906	6	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	iture	OTIV	CT OPT	7116 9 EID	20,000		
	Registr	ar	FEB 26 2010	Beneva !	1. 1	arke						

			For State	State of M	arylan			ent of Hea ate of De				2010	055	541
			Registrar 1. Decedent's Name (First, Middle, La.	ot)			Tunca	ale of De		2. Date of De	Reg. No.	_ 0 1 0	T 0 Time of	(D#-
	Physici	an		<i>'</i>	T				1	Month	Day	Year	3. Time of	
	/Medic		SHIRLEY 4a. Facility Name (If not institution, give	MAE		TEN	T -	T		Feb	20		1318) 171
	Examir	ier	Howard County 6.)	40. 0	1 1	cation of Death			County of Death		
	Eumaral	_	5. Social Security Number 6. S			last birthday)	If Und	der 1 Year If		8. Date of Bir	rth	9. Birth	place (State o	or Foreia
	Funeral Director			□M 2ĂF	69	Yrs.	Month		lours Min.	(Month, Da	av Year)	Cou	_{ntry)} souri	,, , o. e.g.
			Usual Residence of Decedent				L					11110	OULL	
	arylan show		10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation						10d. Inside Ci	
	a-f s	턍	MD Howar	đ		Columb	ia						1 X ∑Xyes	2 No
	or 28	Director	10e. Street and Number				10f.	Zip Code			10g. Citiz	en of What Cou	ntry?	
	72 hours after death with the Maryland Instural", or items 23a or 28a-f show diget Exemiter must be redified at		6260 Foreland Ga	rth, Apt.	A			21	045			USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was De	edent of Hispa pecify Cuban, N	anic Origin? (Spec Mexican, Puerto R	cify Yes or No ican, etc.))- 1	 Race - Ameri Black, White, 		
20	or it	by Fu	1 Never Married 2 Married	1 □Yes 2X					Specify:	, ,		0		
3-003e	ural		3 Widowed 4 Divorced	Year or Dates:		10.0							Black	
,		ete	15. Decedent's Ed (Specify only highest gra	lucation ide completed)		(Give	kind of	sual Occupatio vork done durii use retired)	n ng most of working	7	16b. Kin 	d of Business/Ir	dustry	
7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)			al Work	er		Sta	ate of N	Missour	ci
2	be filed within 72 hours after death with the Maryla that Hygbiene. Id other than "natural", or items 23a or 28a-f show event, the Marical Examinat transitional		17. Father's Name (First, Middle, Last)				,0010		. Mother's Name ((First, Middle				
מש	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ite In	o Be	Henry A.							l Mari				
<u></u>	ges 1 and 2 should be t of Health and Mental If item 27 Is marked o or other traumatic ew	은	19a. Informant's Name/Relationship (19b. Maili	na Addre	ss (Street and	Number or Rural	Route Numb	er. Citv or	Town, State, Zi	o Code)	
2	コモトロ		Ronald S. Gibson/				-		r Lane,	Bowie		20715	,	
ກ	s 1 and 2 if Health item 27 other tra		20a. Method of Disposition		20b. P	Place of Dispo emetery, crei	sition (/	lame of	Da	te	20c. Loc	ation - City or T	own, State	
Dallillion	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					L Crem.	2/27/	2010	0de:	nton, MI)	
<u>=</u>	mit. Sorta		21. Signature of Funeral Service Licer	·		2:	2. Name	and Address o			Fune	eral Hor	ne. P.F	
Ŏ	Depa Impo any is		Dominestr	228/	M011	.03 3	13 5	Talbott	Avenue,		el, l			
		0	23a. Part . Errer the disease, or com sh rk, heart failure. List only	lications that caused	the death	n. Do not en	ter the m	ode of dying, s	uch as cardiac or	respiratory a	rrest,	2020 700	Approximate Interval Bet	e bygen
1	Physician		Immedia ause (Final disease or condition			Fibrill							Onset and I	Death
	/Medical		resulting in death)	Due to (or as			00.10							
	Examiner		Consumate the float constitutions	n Ischen	iie C	ardio	mya	pathy						
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сопъеці	ленсе от).	,	1						
	ecute Ind transi	Examiner	inai inilialeo evenis	c. Diabet	es v	<u>Mellit</u>	'V 5							
5	e exe sian a urial-	Ĕ	resulting in death) Last	Due to (or as	a consequ	uence of):								
0070	ifficate be executed g physician and as the burial-transit	edical		d										
5		Me	IF FEMALE;	20 1/			2 - 17							
ò	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	Ideath 3		pregnancy			2	3d. Date of delive Month		Year
5	he de the a	hysician/M	1 □Yes 2 🗖 No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of d	eath 5L	_l Other	(specify)					,	
Ľ	that the	۵	Part II. Other significant conditions c	ontributing to death b	ut not resu	ultina in the u	nderlvind	ı cause given ir	n Part I.	23e. Did 1	tobacco us	se contribute to	the cause of c	death?
ָה מ	sign d be	d b				3	,,,,,	W 1922		1 🗆	Yes 2□]No 3□ Pro	bably 🏭 I	Unknown
2	requiper /	etec								-				
בַּ	ie law has je 2 s	Completed								24a. Was		24b. Were auto prior to co death?	ompletion of c	available ause of
<u> </u>	n: Th ficate r, pag									1 □ Yes	2 2 No		2 No	
= :	siciar certii recto	Be	25. Was case referred to medical examiner?	Hospital:				Othori	. Place of Death (
5	Phys rthis raldi	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	1 ∐ Inpation		ER/Outpatier 28b. Time o		DUA	4 Nursing Home	e 5 ☐ Resi 3d. Describe			fy)	
5	ending ath. or: Afte he fune	ation	1 Avail 5 ☐ Pending investigation	(Month, Da	y, Year)	Injury	М	28c. Injury at Work? 1 □ Yes	2 □No	d. Describe	now injury	occurred		
	af or Att safter de I Directo d in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, et	ury - At ho c. (Specify	me, farm, str V)	eet, fact	ory, office	28	3f. Location (City or To		Number or Rui	al Route Num	nber,
	e Hospital or Attending Physician: The law requires that the death cert 1.24 hours after death. 1.24 hours after death. 1.24 hours after death. 1.24 hours after death. 1.25 hours after the certificate has been signed by the attending letely filled in by the funeral director, page 2 should be detached for use a	dical C	29a. Certifier (Check only one)	ysician: To the best niner: On the basis o and manner sta	f examina	wledge, deat tion and/or in	h occurr vestigati	ed at the time, on, in my opini	date and place, ar on, death occurred	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	3)

State Registrar 29b. Signature and little of certifier

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

D50377

29d. Date signed (Month, Day, Year)

20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician ROBERT JOHN FLEISCHMANN, JR. 12 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death Examiner ATA CIVISTA MEDICALCENTER Z 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7-22-1927 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **№** M 2□ F Months Days Hours Min 577-32-9980 82 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD. PRINCE GEORGES ACCOKEEK 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15512 CEDAR DRIVE 20607 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ NoA R M Y If Yes, Give 1 9 4 6 - 4 9 Year or Dates: 9 4 6 - 4 9 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ALLIED & OGDEN Elementary/Secondary (0-12) College (1-4or 5+) AVIATION REFUELER AVIATION SER 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT JOHN FLEISCHMANN MINNA DINA WILTZ ၉ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ACCOKEEK, MD. 20607 15512 CEDAR DRIVE VELMA MORGAN-NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State SHINGTON NATIONAL CEM.2-22-1 0 SUITLAND, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licepace MO0479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Farlere Resp Week disease or condition resulting in death) Due to (or as a consequence of): neumona 45peration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown preumona - due to 24a. Was an autopsy performet 1 🗌 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? Failere to 2 □No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1∐Yes 2∭No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only

68760 Box o Division of Vital

the burial-tra detached s been signed b should be deta page 2 funeral director, this or Attending the within 24 hours after deat To the Funeral Director: filled in by completely

Funeral

Director

28a-f show

6

6

and Mental Hygiene.

Department of Health a Important: If item 27 is any injury or other tra once.

Physician

Examiner

/Medical

Baltimore,

石の

D

2

traumatic event, the Medical Examiner must be notified at

State Registrar

31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001

29b. Signatur



MD

of person who completed cause of death (Item 23a) (Type, Print)

stenford

701

29c. License number

D46419

29d. Date signed (Month, Day, Year)

Charles St La Plata, MD 20646

February 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Flack February Josephine Marie 2010 8:35 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F March 23 1918 New York 91 Director 100-10-1403 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Timonium Baltimore Md. 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21093 2525 Pot Spring Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marie Greisch Louis Jaklitsch () 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Flack/ Son 512 Kinsale Rd. Timonium, Md. 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 3-3-10 Farmingdale, NY 4 ☐ Donation 5 ☐ Other (Specify) Charles Cemetery ^{22. Name and Address of Facility} Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph sician/ ASPIRATION PNEUMONTA disease or condition Medical resulting in death) Examiner PULMONARY FIBROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy ormed? 2 **X** No death? 1 ☐ Yes 2 ☐ No Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation 6 Could not be Accident Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and til 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

JONES,

31. Date filed (Month, Day, Year) FEB 2.6 2010

TTMONTUM, MD 21093

2300 DULANEY VALLEY RD.

Hours

1. Decedent's Name (First, Middle, Last) **Physician** Mary Louise Fry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Manor Care- Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🖫 F Director 84 579-28-2015 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f show the Medical Examination and the molified at Director MD Baltimore Parkville 10f. Zip Code 10e. Street and Number 2422 Ellis Road by Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Mental Percy Adams ပ Department of Health and M Important: If item 27 Is marl any injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) Richard E. Fry-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final art 10 mm men **Physician** disease or condition resulting in death) Due to (or as a consequence of):

1 ☐ Yes 2 No 10g. Citizen of What Country? 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 XNo Specify: white Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry At Home 18. Mother's Name (First, Middle, Maiden Surname) Frances Edelen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2422 Ellis Road-Parkville, Maryland 21234 20c. Location - City or Town, State Parklawn Cemetery Feb. 25,2010 Rockville, Maryland 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road Parkville, Maryland 21234 avesT 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

> 24a. Was an autopsy

Other: 4√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

1 □Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 22, 2010

8. Date of Birth (Month, Day, Year)
Aug. 13, 1925

Baltimore

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 🔀 No

9. Birthplace (State or Foreign

10d. Inside City Limits

Maryland

/Medical Examiner

Examiner Physician/Medical 2

signed by the attending physician and be detached for use as the burial-tran certificate

P.O. Box 68760,

of Vital Records,

Division

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director;

Completed Be Certification: To

Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 XNo 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

(Check only one)

29b. Signature and fitle of certifier

29a. Certifier

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

3

Registrar

31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Carey,

5 Pending investigation

6 ☐ Could not be

MD

509 E. Joppa Road, Towson, Maryland 21286

32-Registrar's Signature FEB 26 2010 James S. James

CVA

HBC

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Laminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D31926

1 ☐ Yes 2 ☐ No

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death

28a. Date of Injury (Month, Day, Year)

and manner stated.

9 ☐ Unknown

ORIGINAL

el Allen Ferris		Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H	es Are Le ygiene	egibl	e 2010	05548
- Discontinuit		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De			3. Time of Death
Physicia edical Exami≀		Joel Allen Ferris	Month February	Day 21, 2	Year 2010	2033 hrs
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 500 Upper Chesapeake Driver Bel Air			c. County of Deat Harford	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min	_		//DD/YYYY) 9. Bi Forei	
Director		250-86-5896 XXM 2 F 60 Yrs. Months Days Hours Min	Oct.	19,	1949 c	Carolina
è		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d tow any		Maryland Harford County Abingdon				1 Yes 2 XXNo
te Maryland or 28a-f show fied at once.	Director	10e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Cou	ıntry?
th the Maryland 23a or 28a-f sho notified at once.	Dire	3403 Tree Frog Court 21009		Uni	ted Stat	es
× 8 8	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto		No-	14. Race - Ame White, etc.	rican Indian, Black,
r death or iter	Funeral	Never Married 2 Married 1 Yes 2 X No	,		Specify: Whi	te
rs afte ural",	ã	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of vice in the complete in the compl	work done	16b.	Kind of Business	
72 hou n "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret	ired)		11 -	
15-0036 filed within 72 hours afte I Hygiene. d other than "natural", i, the Medical Ex. miner	Completed	12 N/A Dietary Aid			shley In	<u>. </u>
21215-0036 Duld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica		17. Father's Name (First, Middle, Last) Lin Shechard Ferris Peggy Fo		, Maide	n Surname)	
2121 uld be fil Mental I marked	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I		umber,	City or Town, Stat	e, Zip Code)
MD and 2 sho alth and m 27 is		Robert C. Ferris (Brother) 3403 Tree Frog Court,		lon,	Marylan	d 21009
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	O Date		Location - City o	
Page:		4 Donation 5 Other Specify: Evans Funeral Chapel Feb	_ 23	F 0.	rest HII	1, Maryland
Baltimore, permit. Pages las Department of He Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chape	el & Cr	ema	tion Ser	vices-Belair
Physician	\dashv	3 Newport Drive, For 23a, Part I. Enter(the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or complications that caused the death. Do not enter the mode of dying, such as cardiac or complications that caused the death.	orest_b or respiratory a	rrest, sl	<u>Maryla</u> hock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atherosclerotic cardic				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	٦	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				-
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
uted ransit	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
an an all - tu	ical	X UNPENDED AMENDED 23a,27,permE, g901 3/2/10 TT				
760, icate be exe	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		2	3d. Date of delive	
ox 687 eath certific attending properties as the	sician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn 4 Pregnant at time of death 5 Other (Specify)	ancy		Month	Day Year
Box 68760 e death certificate b the attending physical for use as the bu	ysic	1 Yes 2 No 9 Unknown g Unknown				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacc es 2		o the cause of death? bbably 4 Unknown
rds, require been si	Completed		24a. Wa	as an topsy		autopsy findings available completion of cause of
Recol The law icate has page 2 sh	dmo			formed		
tal Rection: The	au l	25. Was case referred to medical 26.Place of Death (Check	only one)			
Vita hysici this ca	To B	1 V Yes 2 No	ing Home 5		dence 6 Oth	er:
n of ding Ph After 1 funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No	28d. Describ	e now ii	njury occurred	
Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director.	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.				Rural Route Number, City
Divi	Certification	3 Suicide 6 Could not be determined (Specify)	or Town	, State)		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the ca	use(s)	and manner as sta	ated
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier.	at une time, da		d. Date signed (M	
	2	29b. Signature and title of certifier O.C.M.E.			ebruary 22, 20	
1		30. Name and address of person who completed cause of death (Item 23a)	-			
5.5						

Patricia Aronica-Pollak MD. State 31. Date filed (Month, Day, Year) FEB 2 6 2010

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar

10-01462 Asa Fukuhara Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Asa Fukuhara State of Maryland / Department of Health and Mental Hygiene 2010 05549 1- For State Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Month Day February 18, 2010 Medical Examiner 0616 hrs Fukuhara 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3000 Branch Avenue Temple Hills Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours 32 Country awaii 1 X M 443-78-3120 2 F Feb. 14, 1978 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show 28a-f show 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Maryland Prince George's Hillcrest Heights Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3001 Branch Ave. Apt. 626 20748 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White etc. 2 X No 1 Yes Japanese Specify Vietnamese 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 X No specify. ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) United States College (1-4 or 5+) event, the Medical Baltimore, MD 21215-0036 5+ Dept. of Agriculture Engineer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Russell K. Fukuhara Le-Minh-Thuy ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 Catherine Fukuhara (Spouse) 3001 Branch Ave. Apt. 626 Hillcrest Heights, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Buxial 2 Cremation 3 Removal from State permit Page Department o Sunset Memorial Gardens 2/24/10 Lawton, OK Donation 5 Other Specify 22. Name and Address of Facility Becker Funeral 1502 Fort Sill 21. Signatule of Funeral Serlice Livens Mune Blvd., Lawton, OK 73507 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a Head Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the attending physician and ed for use as the burial - transi Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Dav Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? this certificate Yes 2 No 1 🗸 Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 2 1 Yes 28a Date of Injury FOUND: Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pedestrian struck by vehicle death. 5 Pending 1 Yes 2 V No To the Funeral Director: Feb 18, 2010 0601 hrs 2 🗹 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 24 hours after 3 Could not be Suicide or Town, State) 3000 Branch Avenue, Temple Hills, MD determined (Specify) Local Street 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License numbe O.C.M.E. February 18, 2010 of death (Item 23a) 30 None and Wress of person who completed Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	eartment of Health and I		2010 05550
			Registrar 1. Decedent's Name (First, Middle, Last)	Tuncate or Death	Reg. I	3. Time of Death
	Physicia		HELEN FRANZ FINK		February 25,	Day 2010 Year 1:10P M
~	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
()	Examina		Oak Crest	Parkville		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Yea	9. Birthplace (State or Foreign Country)
	Director		212-30-2242		January 19,	1920 Mary Land
3	show	b	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
- Carol	28a-f	lec	Maryland Baltimore Parkville			1 ☐ Yes 2 No
4	a or 2	<u> </u>	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
4	ns 23 must	Funeral Director	8820 Walther Blvd	21234	7 7 1	USA
1000	or iter	ΥF	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
936	ral", c	Completed by	3XXWidowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 XXNo Specify:		Specify: White
2-0	'natu dical	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work	ing 16b	. Kind of Business Industry
2	than the Me	l mo	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)		Private School
α σ	Hygie other ont, th	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	
au E	ental ked c	힏	Charles Freitag		th Franz	on variatio)
ary	c should be filed within 72 hous after beath with the invaryants the and Mental Hydriene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rui	al Route Number, City	or Town, State, Zip Code)
Σ :	and < s Health a tem 27 i			Luiss Deane Drive Balt	imore, Maryla	and 21234
Baltimore, Maryland 21215-0036	Titer Fiter or oth			ematory or other place)		. Location - City or Town, State
tim :	perfilt. Fage 1 and 2 should be more within 72 hours after beath with the waryand perfilt. Fage 1 and 2 should be more within 72 hours after the many fair brook and 1 if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) GreenMount			Itimore, Maryland
Bal	Depa Impo any i	3	21 Jignature of Funeral Service Licenses Conardes	22. Name and Address of Facility ,Mi 6500 York Road Balt	tchell-Wiedel imo <u>re, Maryla</u>	feld Funeral Home Inc and 21212
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
~PI	h sician/	8 8	Immediate Cause (Final disease or condition			Onset and Death
, , , <u>, , , , , , , , , , , , , , , , </u>	Medical xaminer		resulting in death) Due to (or as a consequence of):			
-		je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
, let	Insit	ä	cause. Enter Underlying Cause (Disease or Illijury			
A Page	hysician and the burial-transit	dical Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
9 8	hysicii he bu	dica	d			
387	ling pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	-		
o t	attend for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
Ö	signed by the attending physical be detached for use as the	Physician/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown			
9. E	ned by deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
JS,	been sign	pa	CVA		1 🗌 Yes	2 No 3 Probably 4 Unknown
Sor	as bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Be Be	s certificate has blirector, page 2 s	le C			performed	? death?
tal	sertific sector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec	ck only one)	
	this c	2	1 Yes 2 No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time		ome 5 Residence	6 Other (Specify)
Division of Vital Records, P.O. Box 687	th. : After e fune	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 No	200. Describe now in	ijury occurred
Sio	er dea ector by the	ř	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		and Number or Rural Route Number,
	al Dir led in	log l	building, etc. (Specify)		City or Town, Sta	
Hoen	Funer fed fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation).	stigation, in my opinion, death occurred	at the time, date and pla	ace, and due to the cause(s) and manner stated
7	The interpret of Arenal in the configuration of the configuration of the configuration of the configuration of the completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit of the completed filled in by the funeral director, page 2 should be detached for use as the burial-transit of the completed filled in by the funeral director.	ğ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b, Signature and title of certifier	, death occurred at the time, date and pla 29c. License number		se(s) and manner as stated. Date signed (Month, Day, Year)
*	- ≶ ⊢ ŏ		Mice m Brasies CRAP	R067343	200.	2/25/10
			30. Name and address of person who completed cause of death (Item 23a) (Type,			
			Alice M Brazier 8800 Walther Blvd Park	ville, Maryland 21234		
	Sta		31. Date filed (Month, Day, Year) FEB 2 6 2010 2. Registrar's Signature	ale		
	Registr	ar	LED 20 TOLO DOM			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2010 rebruois /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept6,1934 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Maryland 219-30-6287 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1X Yes 2 □ No Baltimore City Md. Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number death with or items 23a or event, the Medical Examiner must be 21224 U.S.A. 119 North Belnord Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after cartment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or iten Injury or other traumatic event, the Medical Examiner 1 Yes 2 Xo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Shipping Receiving Import Export Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Ellinghaus Charles Hutson ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 2106119a. Informant's Name/Relationship (Type. Print) 179 Virginia Lane. Apt E. Glen Burnie, Md. Brenda Zoch / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Febr dary 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any Injury or once, 25, 2010 Baltimore, Maryland Loudon Park 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Dundalk Avenue Baltimore, Md. Thy 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypoxic respiratory failure
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Pulmonary hyperknostur Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of) by Physician/Medical as 1 attending asn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 1 Tes 2 🗷 No 1 Inpatient 3 🗌 DOA 2 ER/Outpatient 2 28c. Injury at Work? the funeral 27. Manner of Death Date of Injury 28b. Time of Certification: (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

Physiclan: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, I or Attending Fafter death. 24 hours a Hospital

3altimore, Maryland 21215-0036

To the I within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rina Khatn

29a. Certifier (check only

Medical

State Registrar

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year) FEB 26 2010

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 23aPtI,25 per me,2900,02/25/2010dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 201 Physician/ January 17, 5:15 PM Laurence Glass Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 100 Harbor View Drive Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 28, 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Year) 19<u>36</u> 1. M 2 □ F Months Hours 73 Director Yrs 116-34-0717 Usual Residence of Decedent show 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the f Health and Mental Hygiene. The the star of its market and the same of the than "natural", or items 23a or often 27 is market of the than "natural", or items 23a or often fraumatic event, the Medical Examiner must be a followed to the the medical Examiner must be a control of the medical Examiner must be a control. Funeral 100 Harbor View Drive 21230 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ Specify: 3 Widowed 4 Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired College (1-4 or 5+) Elementary/Seconday (0-12) Teaching Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo M. Glass Beatrice Schaenen injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Bland /Friend 13139 Blue Ridge Road Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of Date Jan 21 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2010 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Probable Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of Examiner with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying to for as a consequence on Examin Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be CERTIF Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death g ☐ Unknown the g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Severe coronary outery Division of Vital Records, Completed 2 X No 3 Probably 4 Unknown AIDS - well-controlled Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 ☐ Yes 2 🗙 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After is completed filled in by the funeral programmer. Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

29 Squeene St +300 Baltimore Md 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

				Type or Pri							_		_	ole.	
		1 - State Amer	nd Item	State of M. s 23aPtI,	arylan II,2	d / Depa 5 , 27 , 2 <i>Cer</i>	artme 8a-f tifica	nt of F per te of L	lealth a me g9 Dea <i>th</i>	ind M 02, 0	lental Hy 04/06/2	giene 010d Reg. N	hb 20	10	0555
Physicia		1. Decedent's Name (First Louis Arman	t, Middle, Last,								2. Date of De	eath	L. U	Year	3. Time of Death 1931 P
Medic Examin		4a. Facility Name (if not in			lonto	~	4b. Cit		Location of	Death		40	c. County of		<u> </u>
Funeral		Upper Ches 5. Social Security Number	6. Sex	7. Ag	e (In yrs. la	ast birthday)	_If Und	er 1 Year	If Under 2	24 Hrs. Min.	8. Date of Bi	th		a Rirthn	lace (State or Fore
Director		219-52-6077 Usual Residence of Deced		M 2 □ F	60	Yrs.	Ivionth	Days	Hours	IVIIII.	1 1 ^M 2 ^t 8 D	1949		Count	MD
yland -f show ed at	ctor	10a. State 10b.	County		· ·	, Town or Loc								11	Od. Inside City Lim
the Mar or 28a e notifi	Director	MD Ho 10e. Street and Number	arford		B	el Air		ip Code		-		10g. C	itizen of Wh	nat Coun	1 ☐ Yes 2 ሺ try?
th with ms 23a must b	Funeral	500 Summer						2101		. 0.70	16 M		USA		
Baitimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ □	⊠ Married	 12. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates. 		11	Yes, sp	ecify Cuba	ispanic Origin, Mexican, Specify:	in? (Spe Puerto l	cify Yes or No Rican, etc.)		14. Race - Black, Specify:	White, e	tc.
15-0	Completed		Decedent's Edi	le completed)		16a. Deced	and of w	ual Occup ork done o se retired)	ation during most	of worki	ng	16b. k	Kind of Bus	iness Ind	ustry
within vigione.		Elementary/Seconday	(0-12)	College (1-4 or 5	5+)			,	nt of	Sa1	es	Н	VAC		
Maryland Should be filed th and Mental Hy ty is marked ott traumatic event	To Be	17. Father's Name (First, M Louis Grue	Middle, Last)								(First, Middle orkey	, Maiden	Surname)		
r, Mar nd 2 shoul ealth and m 27 is m ner traum		19a. Informant's Name/RePamela E.	Grue (W			500	Sumn	nerva			Route Numbe			te, Zip C	ode)
Page 1 a ment of H tant: If ite		20a. Method of Dispositio 1 🏻 Burial 2 □ Cre 4 □ Donation 5 □	emation 3 🗆 I	Removal from State	C	lace of Dispor emetery, crem ghview	natory`or	other plac			5-2010		location - C		
Daiti		21. Signature of Funeral S	Sorvice License	e /		22 T	Name a	and Addres	ss of Facility	Sch	imunek 1 Rd Bi	Fun	eral l	Home 210	of BelA
		23a. art 1. Enter the dis- shock, or heart failur	ease, or compl re. List only on	ications that caused e cause on each line	the death										Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		Due to (or as a	ent	1001	7	F	brit	1-1				_	Onset and Death
Examiner	Ļ	Esquentially list condition	. [2	- 6	<u>≈6/e</u>	- C	OFE	nary	A	rlay	4	's c a !	ie	
red nsit	Examiner	if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury	ate	Due to (or as	a consequ	ence of):				//	1 1		7		
9 Ei		that initiated events resulting in death) Last		Due to (or as a	a consequ	ence of):		fly	CERTIFICA	TONAP	ANALY PROVED BY ME	DICALEX	AMINER		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Euneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medical	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 Yes 2 No 9 Unknown	an	3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic Other (U pregnanc					23d. Date Mont		ry Day Year
es that the signed by		Part II. Other significant		ntributing to death b								obacco Yes 2	1 1		e cause of death?
The law requirate has been page 2 should	Completed	Dilated Car	rdiomyo	pathy							24a. Was auto perf	an psy ormed?	24b. We pri	ere autop or to cor ath2	sy findings availal
VICAL IN hysician: The his certificate I director, pa	Be C	25. Was case referred to nexaminer?						26. Pl	ace of Death	n (Check		2 🗆 N	lo 1	Yes	2
OI VIII ng Physic ter this co	욘	1 Yes 2 ☐ No 27. Manner of Death	H	28a. Date of inju	rv	ER/Outpatien 28b. Time of		Othe 28c. Injun	4 ∟ Nur		me 5 Res				·
DIVISION C tal or Attending rs after death. al Director; Afte ed in by the fune	Certificate:	2 X Accident 3 ☐ Suicide 6 ☐	Pending Investigation Could not be	02/21/20 28e. Place of Inju	010	7:02	P M	work 1 \square		No C	naphyl ontras or CT	acti t dy Scan	c rea	ctic inis	on during stration Route Number, r Chesap
Hospital or A Hospital or A 24 hours after Funeral Dire	cal Cer	4 ☐ Homicide 29a. Certifier 1 ➤ Ce	determined	Hospita cian: To the best of	S. (Specify,				data and n		Drive,	ReT	Air,	עויי	
To the Hos within 24 ho To the Fun completed	Medical	(Check 2 ☐ Me only one) 3 ☐ Ce	edical Examin ertifying Nurse	er: On the basis of ex Practioner: To the	xamination	and/or invest	igation, i	n my opinio	n, death occ	curred at	the time, date	and place ne cause	e, and due t (s) and mani	o the cau ner as sta	se(s) and manner s ited.
with		29b. Signature and title of	certifier	w			29	Dc. License	number 035	016	2		brua		22, 201
12		30. Name and address of T. Kevin L	unch	mp 6	15 U	J. M	rint)	nail	Rd.	Su	He 21	27	BelA	SCI	no 2101
Stat Registra		31. Date filed (Month, Day, FEB 26 2	(Ypar)	32. Registra	ar's Signat	barker			·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / Dep	artmei e <i>rtifica</i>			and M		iene	05554
E	Dhysia	ion	1. Decedent's Name (First, Middle, Las	t)						2. Date of Dear Month		3. Time of Death
	Physic /Medi		SHIRLEY MARY C	EURTS						FEBRUAR		
) .	Exami	ner	4a. Facility Name (If not institution, give					Location o			4c. County of I	
	Z X_		2303 Manor Cir		a //a um /a a à himb da		r 1 Year	de Gr		O Data of Right	Harford	
JA.	Funeral Director		5. Social Security Number 6. So 391–32–5009	ox □ M 2 🔀	e (In yrs. last birthda) 75 Yrs.	Months		Hours	Min,	8. Date of Birth (Month, Day)	Year) 9.	Birthplace (State or Foreign Country)
	42		Usual Residence of Decedent					1		June 8	, 1934	Wisconsin
	yland		10a. State 10b. County		10c. City, Town or I	Location						10d. Inside City Limits
	the Marylan 28a-f ehow notified at	to	Maryland Harfor	d	Havre d	le Gra	ce					1 ☐ Yes 2 🛣 No
	or 28	ire	10e. Street and Number			10f. Zi	p Code			1	0g. Citizen of Wha	it Country?
	23a c	Funeral Director	2303 Manor Circ	le		2	1078				USA	
	iteme	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Dece	dent of H	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		American Indian, White, etc.
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 If Yes, Give	No	1 🗆 Yes		Specify:				White
215-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23s or 28s-1 show the Mudical Exercites must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:	160 800		-1.0	- 47				
5	n 72	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)	(Giv	edent's Usi e kind of w DO NOT i	ork done d use retired	ation during most d)	t of workii	ng	16b. Kind of Busin	ess/moustry
212	with iene. ther	E C	Elementary/Secondary (0-12)	College (1-4or 5	0+)	ogram					Educat	ion.
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au	lid be lental ked ked	To B	Herman Carl Wolf	gram				Flo	rence	e Bardea	an Kappel	.1
Maryland	shound N	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Addres	s (Street a				, City or Town, Sta	
	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehov other traumatic event, "in Mudical Examinar must by notified at		Jerome P. Geurts	/ Husband	23	03 Ma	nor (Circle	∋. На	avre de	Grace, M	laryland 21078
)re	of He of He		20a. Method of Disposition		20b. Place of Disp cemetery, cri	oosition (Na	me of other plac	(e)			20c. Location - Cit	
E	Pages nent of ant: If It ury or o		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify						3/4/2	2010 Z	Arlington	, Virginia
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Division	after Direct	Certification:	4 Homicide determined	building, et	c. (Specify)	meet, lacio	y, onice		1	City or Town		n ribiai rioble ivalliber,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai C	29a. Certifier (Check only one) 1 Certifyin Physics Physics Certifyin Physics	reician: To the best iner: On the basis of and manner sta	of my knowledge, det f examination and/or i ated.	uth occurration	sat the tin n, in my op	ne date an pinion, deal	d plana, s th occurre	and due to the c ad at the time, d	ause(s) and manual ate and place, and	of 75 stated I due to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	00 /		29	c. License				9d. Date signed (A	Month, Pay, Year)
			Haran X	Canter	-100		D	575	20		02/2	24/10
	101		30. Name and address of person who d	completed cause of d	eath (Item 23a) (Type	o, Print)		^		21017		<u> </u>
- (UV			BLVD-S	- 1 ,	BEL	CAM	M	D 4	4017		
	Sta Registi		FFR 9.6 2010	32. Registr	ar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Day Year **Physician** 8:05P M Lillian E Goldwine 2010 rebruary /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HEALthcare SALTIMOF SAINT AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours Months Min 215-28-7355 1 ☐ M 2 □ XF 80 Director 13. 1930 Maryland Feb. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 784 Charing Cross Road 21229 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 □Yes 2 No Specify. Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Railroad Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred J. Goldwine Lillian James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any injury or other trau Linda Pollitt-niece 6408 Ave. Seaford DE 19973 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Gremation 3 ☐ R 3 Removal from State Feb.23 2010 Glen Burnie MD Atlantic Crematory 1. Signature of Fure of Service Vicense 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** hour ACUTE CARDIAC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE_MYOCARDIAL INFARCTION Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): be executed and Due to (or as a consequence of) burial-68760. physician at the burial Physician/Medical attending p for use as t Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 D No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) O. 9 Unknown σ. signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy certificate Vital Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To ō 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending Investigation Natural 2 Accident 1 □Yes 2 □No thours after death.

uneral Director: A
ely filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar (URA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerome I SNYDERMD.

022645

900 SOUTH CATON AVENUE BALTIMORE MARYLAND 21229

			Amend 4c, per MD g	Type or Print in Black 1901 13 22 10 TT	ck Indelible In	k. Ensure A	Copies A	Are Legible	•
			For State Registrar	State or waryland /	Certificate of L			0010	05556
			1. Decedent's Name (First, Middle, Last,				2. Date of Death	. No. 2	3. Time of Death
	Physicia Medic		Matha	Goldsmit			Month O 2	Day Year	0 2100 M
	Examir	ier	4a. Facility Name (if not institution, give s JOHNS HOPFINS BA	,		Location of Death		4c. County of Dea	th
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bin	rthplace (State or Foreign
	Director		216-09-7874 1 L Usual Residence of Decedent	91	Yrs.		FebI7, 1	918 Mai	ry1and
	yland f shov ed at	햧	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	r 28a- notifi	Director	Md .	Bal	timore Cit	у	1.40		1 🖾 Yes 2 🗆 No
	with th		437 Imla Street			24-2924	10g	. Citizen of What Co	
	death items ner mi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba		ify Yes or No-	14. Race - Ame	erican Indian,
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give	1 Yes 2X No		ioan, etc.)	Black, Whit Specify:	
2-00	hours natura dical E	lete	15. Decedent's Edi		ı. Decedent's Usual Occupa		16	b. Kind of Business	White
21215-0036	thin 72 ine. than "	Completed	(Specify only highest grad	College (1-4 or 5+)	(Give kind of work done d life. DO NOT use retired)	_			
d 2	led wit Hygie other ent, tt	Be C	8th 17. Father's Name (First, Middle, Last)		actory Wor	18. Mother's Name		Shoe Fac	tory
/lan	d be fi Vental arked tic ev	욘	Walter Novak			Rose St		,	
Maryland	shoulk and I is ma rauma	8	19a. Informant's Name/Relationship (Typ		o. Mailing Address (Street a				
e, N	and 2 Health tem 27	1	Maryann Jecelin 20a. Method of Disposition		72 Wiley R of Disposition (Name of				
mor	Page 1 nent of ant: If it		1X Burial 2 ☐ Cremation 3 ☐ F	Cemete	ery, crematory or other place anislaus C	em 22.2	iary	c. Location - City or	e, Maryland
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other tonce.		21. Signature of Funeral Service License	V	22. Name and Addres	s of Facilit Racz	orowski	Funera	1 Home, PA
<u>m</u>	e a T E e	- 1	Tolan M	h				imore,	Md. 21222
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	_		respiratory arrest,		Approximate Interval Between Onset and Death
	Ph sician/ Medical		disease or condition resulting in death)	Due to (or as a consequence of Cerebovo	of:				2 days
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinlury	Director (Unide a concequence	oly.				
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90	te be ex nysician ne burial	dical		d		_			
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XOX (eath ce attend	ician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 1 No	1 Live Birth 2 Fetal death 4 Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of de Month	livery Day Year
O. B	requires that the der been signed by the s should be detached	² hys	g 🗌 Unknown	9 Unknown					
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ords	requir been s should	Completed					1 Yes		robably 4 Unknown
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аЕ	ician: The certificate rector, pag		25. Was case referred to medical examiner?		26. Pla	ace of Death (Check o	-	No 1 ⊔ Yes	s 2 🗆 No
r Vit	Physic this ce al direc	욘	1 ☐ Yes 2 ANO	ospital:		4 ☐ Nursing Hom	e 5 🗆 Residence	e 6 ☐ Other (Spec	cify)
Division of Vital Records,	ding F th. After funer	Certificate:	Natural 5 Pending 2 Accident Investigation		Time of 28c. Injury work?		d. Describe how in	njury occurred	
risio	Atter er dea rector: by the	ertifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)				and Number or Ru	ral Route Number,
Ω̈́	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		ZX -				City or Town, St	,	
	e Hosp 124 ho e Fune eleted f	Medical	Check 2 □ Medical Examine	cian: To the best of my knowledge, er: On the basis of examination and/o Practioner: To the best of my knowl	or investigation, in my opinior	n, death occurred at tl	ne time, date and pl	ace, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	Tradition to the boot of my known	29c. License			Date signed (Monti	
			J.6500	~ M. D	RES-1	000	Ŧ	eb 16 2	010
-	6V		30. Name and address of person who con Temilat O.			20000000			Heck ann scinith
	Stat	e	31. Date filed (Month, Day Year) FEB 2 6 2010	32. Registrar's Signature	nopuns o	-cigvien,	THE WILLTH	CIN DVE, BO	WITHER HIN -
	Registra	ir	LED SO SOIL	CHURCHEN P. 194					

			State of Mary		artment of F			ene 3. No 20	100	555
i	Physic	ian	Registrar 1. Decedent's Name (First, Middle, Last) HAMILTON ELIZABETH HALI				2. Date of Death Month FEB.12,		Year	Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number) 8860 BRIDGETT LANE			r Location of Death		4c. County CHARL	of Death	301 "
	Funeral Director		060-28-5679 1□M2\x	yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 1 - 5 - 1 9	(ear) 28	g. Birthplace (Country) BELGIU	State or Foreig
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c MD . CHARLES	c. City, Town or Lo	walborf					side City Limit
	h with the 23a or 28a	al Director	10e. Street and Number 5005 RED HORSE COURT		10f. Zip Code 206	03		g. Citizen of W	Vhat Country?	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a l'exical Exeminar must be retified at any once.	d by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 🔏 No	lispanic Origin? (S an, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)	Black	e - American Ind k, White, etc. ::WHITE	tian,
21215-0036	ed within 72 h ygiene. ier than "natu t, Ire Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2 4	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of world) ALIST	king S S	T.MAR CHOOL	SINESS/Industry YSC BOARD	
Maryland	should be filed within nd Mental Hygiene. marked other than ımatic event, Ire I	To Be	17. Father's Name (First, Middle, Last) WILLIAM HAMILTON MOORI			ELIZABI	ne (First, Middle, Ma ETH GRAY	BASS	· 	
	and 2 sho ealth and I n 27 is ma er traums		19a. Informant's Name/Relationship (Type. Print) SALLY HALSTEAD-DAUGHTER	8860	BRIDGE'	TT LN.	LA PLAT			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		1 Burial 2 to Cremation 3 Li Removal from State	OPOLITA 22	2. Name and Addre	TORY 2-	Date 20 14-10 AL L SERVIC	EX.,V		tate
18760,	Physician bahysician and bhysician and bhysician and the prival-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Due to (or as a cor Due to (or as a cor d.	death. Do not ent	LA PLATA ter the mode of dyir			.t.,	Appi Inter Onsi	roximate val Between et and Death
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 2c. If yes, outcome of properties of the past 12 months? 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		23d. Dat	te of delivery onth Day	Year
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	ysicia is cert directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 🗌 ER/Outpatier	nt 3 🗆 DOA Oth	6 P.	th (Check only one) ome 5 Residen		er (Snecify)	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ar) 28b. Time o	f 28c. Injur Worl M 1 □		28d. Describe how	injury occurr	red	ite Number
Div	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide building, etc. (Si	pecify)y knowledge, deat	th occurred at the ti	me, date and place	City or Town,	State) use(s) and ma	anner as stated	
_	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only one) 2	mination and/or in	29c. Licens	ppinion, death occu	rred at the time, dat	te and place, a	and due to the o	cause(s)
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) 6 P	lake	- MS	2	064	16
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Patrick Albert ,2010 8:22p M February22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bayview Medical Center Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan4,1950 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🛣 M 2 🗆 F 214-54-4230 60 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show if of Health and Mental Hyglene.
If Item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Wedical Examination must be notified at Director 1 Yes 2 □ No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 428 Joplin Street 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2X No Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 □xNo Specify: 2 Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rail Road 12th Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Hoyt ဂ္ Gertrude Mack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 is
any injury or other trau Kathleen Hoyt (Wife) 428 Joplin Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 □XBurial 2 □ Cremation 3 □ Removal from State St. Stanislaus Cem: 27,2010 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Livensee 1201 Dundalk Avenue Baltimore, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each sine. Immediate Cause (Final disease or condition resulting in death) 0 cara **Physician** /Medical iabetes Mellity Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and Due to Box 68760. IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🙀 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 1 Inpatient 2 KER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of oertifier 29c. License number 29d. Date signed (Month, Day, Year) D 44793 February 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Sanai, M.D. 6730 Holabird Avenue Baltimore, Md. 21222 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 26 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05559 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rhruar dhas 6:20PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COURS Baltimore N/A Hospita 5. Social Security Number 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign oct. 28 Pear) Country)
MD Hours Min Director 220-64-4255 53 1956 Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/A MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2209 W. Baltimore Street 21223 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify:Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th N/A N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Levy Johnson Barksdale Wilsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Western Winds Cir Balto., MD 21144 Tyrone Parker/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State tery, crematory or other Zion Cem 3/4/10 4 ☐ Donation 5 ☐ Other (Specify) Lansdown, Signature of Funeral Service Licensee 22. Name and Address of Facility Beverly D. Cromartie F/s n Ave. <u>Balto., MD 21223</u> Edmondson 700 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner SIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events nei Physician/Medical Exami 0 attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months
1 Yes 2 No Pregnant at time of death Month Day Year g 🗌 Unknown Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page performed? Yes 2 No 2 HNO 1 Tyes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DNOVAT ARKES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02-21-2010 **Physician** Donald H. Jeffries 510 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 201 Oak Leaf Circle #E Abingdon Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06-07-1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F VA 76 229-36-5000 Director Usual Residence of Decedent 10d. Inside City Limits 10h Count 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating that he motified at 1 ☐ Yes 2X No MD Harford Abingdon **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21009 USA 201 Oak Leaf Circle #E 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: \$ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CSX Car Accounting 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Charles W. Jeffries Lillian Pace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 1205 Ann Street Huntington, WV 25703 Ida Walker (Daughter) other t Department of Heal Important: If item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 N Burial 2 □ Cremation 3 □ Removal from State Spring Valley Mem.Gar 02-27-2010 Huntington, WV 4 □ Donatjon 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Fuenral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final ANCREATIC CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** IVER METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by page 2 should be detact 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 20 No 1 ☐ Yes al or Attending Physician: Tis after death.

I Director: After this certificat Be (funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 No 1 Tyes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2-22-2010 CM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMOUD 2227 040 EMMONTON RD MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** a 11:50 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Genesis Health Care Severna Park nder 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2 □ F 214-30-3440 Director March 23 1933 Maryland 76 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I'm Medical Exprising 1 mest be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Yes 2 ☐ No Anne Arundel Severna Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ellerslie Road Funeral 674 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1XXYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify. \$ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automechanic/State Inspector 12th Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ashby Jenkins ဂ Nellie Chesgreen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gambrills, MD Mary Ellen Jenkins/Wife 1403 Wigeon Way, #3, 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or 1 Burial 2 □ Cremation 3 □ Removal from State 2/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Savage Cemetery Savage, MD Signature of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate wuse (Final Physician neumonia 10 hours disease or condition resulting in death) /Medical (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a I be detached f 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 ☐ Yes 21 1 ☐ Yes To the Hospital or Attending Physician; "within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ca 29a. Certifler 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

dame and address of person who completed cause of death (Item 23a) (Type, Print)

05562

			1 - For State Registrar	State of Ma	ai yiai iu	-	rtificate of		Mental Hyg R∈	eg. No.		
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	Funeral		Social Security Number 6. 8	Sex 7. Age	e (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth			lace (State or Foreign try)
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, t	or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of V	Vhat Coun	try?
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9	item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 □Yes 2X1		13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Ye's or No- to Rican, etc.)		e - Americ k, White, e	
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aryla	, E & E	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailii	ng Address (Street		ural Route Number,	to be a	State, Zip	Code)
, Mi	of Health item 27 i		Anisa Harris /	Daughter		3102	Sweetbay	Drive, E	idgewood,	Maryla	ind 2	1040
more	2 = 1		20a. Method of Disposition 1 ☑ Buria 2 ☐ Cremation 3 ☐	Removal/from State	20b. Pla	ce of Dispo netery, crei	sition (Name of natory or other place	ce)	Date 2	0c. Location -	City or To	wn, State
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OI V	this ce	၉	1 Yes ≥No	Hospital: 1 ☐ Inpatie	nt 2 EF	R/Outpatier	t 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 XResider	nce 6 Othe	er (Specify)
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e Hospit	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state	examinatio	edge, death n and/or in	occurred at the tirvestigation, in my o	me, date and place	and due to the ca rred at the time, da	use(s) and ma te and place, a	inner as st and due to	ated. the cause(s)
To th	withii To th comp	Me	29b. Signature and title of pertifier				29c. License	e number	29	d. Date signed	(Month, L	Day, Year)
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1) v		30. Name and address of person who							·	-	
	Sto	to	Ashkan Bahrani, 31. Date filed (Month, Day, Year)	M.D. 32. Registra	r's Signatur	S. At	wood Road	d, Suite	200, Bel	Air, M	D 21	014
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05563 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** FEB. 2010 ALICE ELIZABETH **JONES** 6:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner BALTIMORE CATONSVILLE MANOR CARE CATONSVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth DEC. 5, 1949 9. Birthplace (State or Foreign 1□ M 2□ F Months Days Hours Min. MARYLAND 217-58-0232 60 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕍 No BALTIMORE MD LANSDOWNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4169 HOLLINS FERRY ROAD UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1▼17es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A HOMEMAKER AT HOME 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) EARL BAKER ပ္ UNKNOW IN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE W. JONES/ HUSBAND 4169 HOLLINS FERRY RD. LANSDOWNE MARYLAND 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 Cremation 3 ☐ Removal from State GLEN HAVEN MEM. PARK FEB. 26,2010 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD. 21. Signature of Funeral Service Licensee AMEROSE FUNERAL HOME OF LANSDOWNE allicia am! 2719 HAMMONDS FERRY RD. LANSDOWNE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE OHNS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à NFECTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □ Yes 2 ANO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. 24 hours after death Funeral Director:

Funeral

Director

or 28a-f show

r than "natural", or items 23a or 28a-f shorthe Medical Examiner rust be notified at

17 Is marked other traumatic event, II

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event

Physician

/Medical

and

attending physician

ed by the a detached f

signed by t I be detach

has

After this

filled in by the

the

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

within 2

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

BUSINESS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210

M.D

ORIGINAL

CENTER

29c. License number

D0059107

PRIVE

29d. Date signed (Month, Day, Year)

02-23-2010

REISTERSTOWN

mo 2/136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05564 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** M Louis V. Karko February 19,2010 6:49P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Balto. Rosedale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1X M 2□ F 88 220-09-8775 Director <u> April 15,1921 Pennsylvania</u> Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandary in ust the routhed at Md. Balto. 1 ☐ Yes 2 X No Dunda1k Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4144 Beachwood Rd. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Wes 2 No If Yes, Give Year or Dates: 1943-1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No \$ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Steamfitter Union 486 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Karko Patricia Chesnauskas ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Perry Hall Md. 21128
Date 20c. Location - City or Town, State Louis F. Karko 9910 Richlyn Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-24-2010 4 Donation 5 Other (Specify) Most Holy Redeemer Balto. Md. 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee Bucin G 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rig Immediate Cause (Final disease or condition resulting in death) **Physician** hT. SMAL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death.

Euhours after death.

E Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burtal-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an autonsy perform 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Yes 2 □ No Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 📉 No ta Fabruary 152010 Un Known 2 Accident 6 ☐ Could not be 28e. Place Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Nymber or Rural Route Number. City or Town, State) 44.443.20ch wood Rd Dundalk, MD 2122.2 4 Homicide Dundalk Itoma 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier To the within 2 29b. Signature and title of dertifle 29c. License number 29d. Date signed (Month, Day, Year) ebruary 22, 2010

21215-0036

Maryland

Baltimore,

SIMO

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

Trimble 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** Z320101235PM ebruar /Medical Qunty of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner KPS 0 5. Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Country) 1 □ M 2 🙀 F 214-22-4732 87 June 21, 1922 Maryland Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Arnold Maryland Anne Arundel with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e ral", or items 23a Examiner must b United States 1498 Grandview Ct. 21012 by Funeral Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify 3√ Widowed 4 Divorced Year or Dates: White the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 12 Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Mynard E. Lake ပ Nellie Clement 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other traugonce. Sue C. Verillo / Daughter 1498 Grandview Ct., Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 27. 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. Elkridge, Maryland e of Fun 1 I Salvice Lidensee 22. Name and Address of Facility 21. Signati Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 2 MD 21061 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 18ar disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a gonsequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 00 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) this c 1 ☐ Yes 2 No Hospital: Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours are: Cother To the Funeral Director: Af

> State Registrar

29b. Signature and title of certifier

29c. License number R100 599

29d. Date signed (Month, Day, Year) February 23, 2010

, Copper Riber, 710 Obrecht Rd, Sykesville, Maryland 21784

Donnie S. DANK 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 25,27,28a-f per me, g,000,02/226/20,100 Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** 292010 anvary Alice Louise Kohlman /Medical 4a. Facility Name (If not institution, give street and number) 4. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL Himore Ba AGNES If Under 1 Year | If Under 24 Hrs. 4 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Dec. 133, 1923 Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖵 F Months 384-14-9764 86 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at 1, Yes 2 □ No Director Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 1249 Pine Heights Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 1 Yes 2 No
If Yes, Give
Year or Dates: WW II 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: White Maryland 212*5036 1 ☐Yes 2 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be file f Health and Mental H Item 27 is marked oth Trembley Rosalie Hamilton Fred other traumatic P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1249 Pine Heights Ave, Baltimore, MD 21229 Joseph E. Kohlman (HUsband) permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 2/2/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ntracrar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a sunsequence of) Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be execute burial-trai Due to (or as a consequence of) CERTIFICATION 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) 9 Unknown Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? or Attending Physician: The 1 ☐ Yes 2 ☐ No Vital 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2⊞N Medical Certification: To of this 27. Manner of Death 28a. Date of Injury
Found Day, Year)
01/22/2010 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Injury Hatural 2 Accident 5 ☐ Pending 1 □Yes 2X No Unknown investigation Unknown M within 24 hours after death To the Funeral Director: 6X Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Home 28f. Location (Street and Number or Rural Route Alumber. City or Town, State) Found: 1249 Pine filled in by determined 4 Homicide Heights Avenue, Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D DOY TYS Janvar.

(Item 23a) (Type, Print)

90 v (ato- Avenue Baltmore asserble M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1

State

Registrar

31. Date filed (Month, Day, Year)

FEB 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 6:45 A <u>Oakie Marie Kennedy</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 927 Conowingo Road Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours (Month, Day, Ye Country) North Director 82 217-62-6252 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 927 Conowingo Road 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Force þ Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 🔀 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: is marked other than "natural", Specify: 3 Widowed 4 Divorced Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Shoe Manufacturer 6 <u>Assembly Line Workeır</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen (unk) Halsey Lola Mae Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Robert C. Kennedy / Husband 927 Conowingo Road, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 and Department of Hall Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Darlington Cemetery 4 ☐ Dongtion 5 ☐ Other (Specify) 2-27-10 Darlington, Maryland of Fund al Service License 22. Name and Address of Facility

McComas Funeral Home, P.A. 1317 Cokesbury Rd. Abingdon, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause of each line aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final -ND Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed and that initiated events resulting in death) Last physician a the burial-Medical Box 68760 as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy Physician/ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ■ No Month Day Pregnant at time of death 5 Other (specify) ed by the a q 🗌 Unknown g Unknown P.O. | . Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown been signated the second of th Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate I 1 ☐ Yes 2 PNo director, **Division of Vital** Be as case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 🖪 Natural injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year

26

FEB

death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	e of Maryland / Department of Health and Certificate of Death	Mental Hygiene Reg. No 2010 05568
	Physici		Decedent's Name (First, Middle, Last)	Koontz	2. Date of Death Month Day Year February 3. Time of Death 17-20 M
The same of	/Medic Examir		4a. Facility Name (If not institution, give street and		
			The Johns Hopkins Hospita 5. Social Security Number 6. Sex	Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth 9. Birthplace (State or Foreign
- Ta	Funeral Director		Usual Residence of Decedent		8. Date of Birth (Month, Bay, Year) 9. Birthplace (State or Foreign Country) Country England .
	yland how at		10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland aritment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	Director	10e. Street and Number	Bel Ar	1 ☐ Yes 2 No
	th with 23a or st be r		1713 Fdwin 1)r. 21015	1) S A
	er deal	Funeral	11. Marital Status 12. Was Arme	Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (See Forces? If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.
920	urs afte	ğ	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	d Forces? If Yes, specify Cuban, Mexican, Puert (s, Give 1 □ Yes 2 ▼ No Specify: or Dates:	specify: White
2-0	72 hou natura Jical E	eted	15. Decedent's Education (Specify only highest grade comple	16a. Decedent's Usual Occupation (Give kind of work done during most of wo.	16b. Kind of Business/Industry
21215-0036	within ene. than " he Mec	Completed	Elementary/Secondary (0-12) Colleg	2 (1-4 or 5+) (1/4 or 5+) (1/4 or 5+) (1/4 or 5+)	tor Proctor + Gamble
	be filed withintal Hygiene.	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Surname)
Maryland	should band Ments marked	户	John Lew	is Green man	capet K. Cunningham
Ma	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (Type, Print)	SNUS 1713 Edulin Or	ur Route Number, City or Town, State, Zip Code)
Jre,	es 1 and of Health fitem 27 rother tr		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fr	rom State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date a0c. Location - City or Town, State
Baltimore,	Department of Important: If it it any injury or one		4 Donation 5 Other (Specify)	Lyans tuneral grape 190	1/10 Furcest Hill, MD
Bai	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee	22. Name and Ad less of Facility	Funcial Chapel-Beithr
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	ast caused the death. Do not enter the mode of dying, such as cardial or each line	c or respiratory arrest, Approximate Interval Between
			Immediate Cause (Final disease or condition	neumonia	Onset and Death
			resulting in death)	e to (or as a consequence of):	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	en small cell lung cancer	
X	ecuted ind -transit	Examine	that initiated events C	e to (or as a consequence of):	
,092	ate be executed hysician and the burial-transit	dical E	of desired and des	s to (or as a consequence of).	
687	tificate b g physion	Medi	IF FEMALE:		
Box	death certifi attending I d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	, outcome of pregnancy ive birth 2 = Fetal death 3 = Ectopic pregnancy	. 23d. Date of delivery Month Day Year
P.O.	the de y the a ached	hysi		rregnant at time of death 5 ☐ Other (specify) Jnknown	
<u>ର</u> ଫ.	v requires that the death been signed by the atter should be detached for	δ	Part II. Other significant conditions contributing	to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ✔ Probably 4 ☐ Unknown
corc	requii	Completed			1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available
B.	The law e has l	ф			autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No
Division of Vital Records,	ne Hospital or Attending Physician: n 24 hours after death. ne Funeral Director. After this certific pletely filled in by the funeral director	Certification: To Be C	25. Was case referred to medical examiner? Hospital:		th (Check only one)
			1 Lifes 2/1/10	Inpatient 2 □ ER/Outpatient 3 □ DCA Other: 4 □ Nursing Hi ate of Injury 28b. Time of 28c. Injury at	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
			1 Natural 5 ☐ Pending (/ 2 Accident investigation	Month, Day Year) Injury Work? M 1 □ Yes 2 □ No	,,,
			3 ☐ Suicide 6 ☐ Could not be determined b	lace of injury - At home, farm, street, factory, office uilding, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
			29a. Certifier (check only Medical Evaminer: On the	the best of my knowledge, death occurred at the time, date and place ne basis of examination and/or investigation, in my opinion, death occur	, and due to the cause(s) and manner as stated.
		Medical	one) end	manner stated. 29c. License number	
	5 ≥ 6 ⊗	_	Jelle by thether	M.D. D68872	Ebway 24, 2010
	10			cause of death (Item 23a) (Type, Print)	
	Sta	ie_	KUL W. Mitchell 31. Date filed (Month, Day, Year) 3.	2 Projectrar's Signature	North Wolfe St, Baltimore, MD, 21287
	Registra		FEB 2 6 2010 🗸	Even S. Sarla	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G906 8/23/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 5569 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month 11:46 **Physician** 2010 LeRoy Kamzura /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimor Rosedale ial Security Number 6. Se Hospit ent al Under 24 Hrs 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Day Birth Birthplace (State or Foreign Country) **Funeral** Vear Hours Min Months Davs 1**X** M 2□ F Pennsylvania Director 219-18-8964 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, The Medical Examiner must be notified at 1 □Yes 2 N No **Funeral Director** Chase MD Baltimore Co. 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21220 116 Cowhide Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 ☐ Never Married 2 🔀 Married |Kavn ZuRA , LLroy Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel N/A Tractor Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Antoinette Lorinavik Mathew Kamzura 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 116 Cowhide Circle Chase, MD 21220 Civiline Kamzura-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Bayview Crematory 2-26-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiac arr disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DE Sequentially list conditions Due to lor as a consequence of : Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last · Possible hemorrhage versussepsisdue to septic artheitis Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Dav Year 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 Ca 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🛂 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Man yer of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year)
FEB 26 2010 00 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}24 2010 Physician/ FEBRUARY BARBARA **KEYSER** 4:40 A^{M} 7 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE g. Birthplace (State or Foreign Birthpiac Country) MD 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Min. 1 □ M 2 🛛 F MT704/1958 51 Yrs. Director 219-50-2904 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🕅 No MD BALTIMORE REISTERSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 10914 BASKERVILLE ROAD 21136 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DIRECTOR DAY CARE 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ KURT ZION SHIRLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10914 BASKERVILLE ROAD, REISTERSTOWN, MD 21136 HOWARD KEYSER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK! 2/25/2010 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mixed acinar and neuroendocsine concur Physician/ years disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to inflict date cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 2 X No မြ ER/Outpatient 3 DOA 1 Inpatient 2 I 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number CRNP R149194 Hebruay 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Suik 4105. Touson, 21204 Grant N. Chales 6701 31. Date filed (Month, Day, Year) State FEB 2 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Leite Physician/ Monti elen 1211 P Medical 4a. Facility Name (if not institution, give street and number, pr Location of Death Examiner 4c. County of Death of Maryla Hospitals Timore If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 Months Hours Country)
Washington DC 6 Director Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any hipury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1415 Washington Avenue 21144 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: While 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Rusiness Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bill Collector Collections Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Lillian Mae Unknown Kenneth William Redd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Leite / Husband 1415 Washington Avenue Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 03-01-2010 Crownsville, Marvland Signature of Funeral Se we Livense Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MU disease or condition resulting in death) Medical Due to (or as a consequence of) Examine eft Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a, Was an autopsy director, page 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA Other: ပု 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 🗌 No Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year 1987

Registrar

DHMH 17 Rev 7/2009

State

225 Greene St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)

FEB 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 10, 2010 Inkeri Katri Pajasvaara Lindholm 9:00 pmM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Citizens Care & Rehabilitation Ctr Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 577-50-9833 **Director** Finland Usual Residence of Decedent 28a-f shov 10b. County Frederick State notified at 10c. City, Town or Location Frederick 10d. Inside City Limits Director Maryland 1 XYes 2 ☐ No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 21 Frederick Avenue U.S.A. 21701 tems 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White "natural". Specify: 3 X Widowed 4 Divorced id Mental Hygiene. marked other than "natur matic event, the Medical I 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Homemaker Elementary/Seconday (0-12) College (1-4 or 5+) Own Home it. Page 1 and 2 should be filed with intrnent of Health and Mental Hygier ortant: If item 27 is marked other thiury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Viktor Bloquist Ohberg Karin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Karin Belsheim, Daughter 21 Frederick Avenue, Frederick, Maryland 21701 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Smithsburg Crematory of other place)

Smithsburg Crematory Feb 14, 2010 Smithsburg, Maryland 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Euneral Service Lo 22 Reenel de Bastord P.A. Funeral Home 106 E Church St, Frederick, Maryland 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the cause of t Approximate Interval Between Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 18 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy perform 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continued in Nurse Prantice of T. In the cause of the cau (Check only one 29b. Signature an 29c. License number 29d. Date signed (Monty), Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete M.D., 300 West Ninth Street, Frederick, Maryland 21701 Robert L. Kaufmant/ 31. Date filed (Month, Day, Year) 32. Registrar's Şignatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CITCH FIELD 12.45 PM GEOLGE HANTON FEB. 20 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARROLD METROUP HARFORD HOSP MAC HAVRE DE GRACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 26, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ☐ F 213-26-7711 Maryland 1928 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Edgewood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21040 205 Kennard Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Mes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Model Maker U.S. Government Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Sadie S. Johnson Hanson Herman Litchfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 302 Crestwood Drive, Edgewood, Maryland, 21040 Daniel Litchfield / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 D Remova from State Bel Air Memorial Gdn. 2/26/2010 Bel Air, Maryland tu of Fune 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULTONARY DISEARE Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONCESTIVE HEART FACUERS 1 Yes 2 No 3 Probably 4 Unknown Completed PULLMONART HYPERTENSIONS 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 2**℃** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 4 hours after death 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) within 2.

Box 68760.

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Records,

Vital

31. Date filed (Month, Day, Year FEB 26 2010

29b. Signature and the of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A I A CUEAS THAT UP ION TOTOMAL HOSTICAL LAN SUEASTUN

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

HAURE DE GRACE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stella Ann Labu February 24, 2010 7:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House Parkville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 18,1924 Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F 213-20-1110 85 Director Pennsy Ivania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 200. 1000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Not tingham Director 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 Burnsway Court U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√ No If Yes, Give Year or Dates: 1 ∐Yes 27☑No Specify: Specify: White 3 TWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Banking Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dan Barbu Elizabeth Mija ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dama Lozoskie/ Daughter 25 Burnsway Court, Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/01/10 Parkville, Maryland Parkwood Cemetery 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee 8800 Harford Road, Parkville, Maryland 21234 2 a. Pa 17. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmed ate Cause (Final Physician mentia liseas or condition lesuling in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unleaded or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): signed by the attending physiclan and the detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1∐Yes 2.1SpNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2⊠No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physician: The law requir within 24 hours after death.
To the Funetal Director. After this certificate has been sompletely filled in by the funeral director, page 2 should

Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 021022 2-25-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALEUSICI MD egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible lak, Ensure All Copies Are Legible.
AMEND TITEM#8perFH, 6901, 3/8/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month tha ong **Physician** February 2010 /Medical 4a. Facility Name (If not Institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, | 3. | 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1939 **Funeral** 1 □ M 2 X F 219-38-867 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County ā Yes 2 □ No Funeral Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s my Injury or other traumatic event, the Medical Examiner must be notified once. timore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Ellwood Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: þ Specify acl 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Secondary (0-12) College (1-4 or 5+) Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece Bato.MD 21213 3 Removal from State (Specify) 21. Sig nature of Funeral Se License 23a. Part . Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Possible artiu dissection **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Was decedent program in the past 12 months? 1 □ Yes 2 No Live birth 2 Fetal death 3 Tectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 Tyes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 2 No 1 Tyes 25. Was case referred to medical examiner?
1 ★ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 TYes 2 No Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIFFANY FONE 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State back

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Registrar

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State of Maryland / Department of Health and Mental Hygiene 05577 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Alton 2010 7:45 A M 24 Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 8513 Imperial Drive Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 27 1937 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min. Months Hours 1 ☑ M 2 □ F 72 Director 533-36-5845 Sept. Oregon Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Mcdianl Examination of the profilled at Director 1 ☐ Yes 2 No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8513 Imperial Drive Completed by Funeral 20707 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ould be filed within Elementary/Secondary (0-12) 12th College (1-4or 5+) Analyst NSA is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t and 2 should by Health and Ment Everett Martin Lucille Mae Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Virginia Anne Martin/Wife 8513 Imperial Drive, Laurel, MD20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 2/25/2010 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. ances 23a. Part Einer the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shake, or learn failure. List only one cause on each line.

Immediate Cruse (Final disease or condition resulting in death)

a. End-Strug Liver Disease M001103 313 Talbott Avenue, Laurel, MD 20707 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Explored injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Hinknown 9 Unknown ģ nis certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 □Yes 2 No 1 ☐ Yes 2XXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ∐ Yes 2 ₺ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After thi etely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only within 2 To the (29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DUU57465 VISKAJAPANIL N.D 2/25/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapakse, MD. 28355 mith Av. S-203, Baltimore, MD. Z1209 31. Date filed (Month, Day, Year) State

Registrar

05578

			1 - Registrar Certificate of Death		g. No. 2010	05578		
	Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Pay 15 Year Year	3. Time of Death		
il.	/Medio	cal	JOSEPHINE BURGER MECHLING 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	FEBRUAF	4c. County of Deat			
	Examir	ier	Talbot Wing - Heron Point Chestertown		Kent			
	Funeral Director			8. Date of Birth (Month, Day, May 23	9. Bir 1915 Mai	thplace (State or Foreign huntry) Tyland		
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	e Mary ka-f sh tiff d	ctor	MD Kent Chestertown			1⊠Yes 2 No		
	vith the	Funeral Director	10e. Street and Number 10f. Zip Code		g. Citizen of What Co	ountry?		
	ns 23	neral	240 Heron Point 21620 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto		U.S.A. 14. Race - Ame	erican Indian,		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, In "Medon Eva", Increment to mill date.	Completed by Fur	1 Never Married 2 Married 1 Yes 2 No		Black, White	White		
15-	in 72 h "natu Kelion	6b. Kind of Business	Industry					
212	Own Home	9						
	nd 2 should be filed within alth and Mental Hygiene. 27 is marked other than ir traumatic event, I'm I'm	Be	17. Father's Name (First, Middle, Last) Louis John Burger 18. Mother's Name Martha		aiden Surname)			
Maryland	should be fand Mental I	입	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura		City or Town, State.	zio (Midra) 21010		
	and 2 salth ar 27 is sr trau				Herman Hwy. Earleville			
Baltimore,	oermit. Pages t al Department of Hei mportant: If item any injury or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	0c. Location - City or	Town, State		
tim	permit. Pages Department o Important: If i any injury or once.		4 Doparton 5 Other (Spacify) Reflt Cremation 1/1/	//10 8	Smyrna, I	DE.		
Ba	Depa Impo any i		21. Signa up of fundal Service renset M00510 22. Name and Address of Facility Galena Funeral H 118 West Cross S	ome of	Stephen	L Schaech		
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between		
	Physician		Immediate Cause (final disease or condition Pneumonia			Onset and Death 3 days		
4	/Medical Examiner		Due to (or as a consequence of): Dementia, Advanced					
		Jer	Companie the liet conditions					
	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if my leads to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):					
60,	be exician a	a E	resulting in death) Last Due to (or as a consequence of):					
68760,	tificate ng phys as the	Medical	d					
P.O. Box	Attending Physician: The law requires that the death certificate be executed refeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year		
S, P	s that gned b	by Pt	Fait ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Fait i.	23e. Did tob	acco use contribute to	the cause of death?		
Records,	w requires s been sign should be	ted t	Atrial Fibrillation	1 ☐ Ye	s 2 1 € No 3 P	robably 4 🗌 Unknown		
3ec	: The law cate has b page 2 st	Completed	Congestive Heart Failure	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of		
tal	ian: The rtificate tor, pag		Aortic Stenosis 25. Was case referred to medical 26. Place of Death	1 □Yes 2	No 1 □Yes	3 2 □ No		
of Vital	lysicia iis cert direct	To Be	examiner? 1 Yes 2 No			ecify)		
0 0	ding Phy h. After thi funeral (27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1X Natural 5 □ Pending (Month, Day, Year) 28b. Time of 1 lnjury 28c. Injury at Work?	28d. Describe how	w injury occurred			
Division	Attend er death. ector: / by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or R	ural Route Number,		
ō	oital or urs aftu rral Dii							
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cared at the time, da	iuse(s) and manner a	s stated. e to the cause(s)		
	To t To t	×	29b. Signature and title of certifier D 004158	1	2 - 16 - 2			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, M.D. 122 Speer Rd. Chestertov	MD MD	21620			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	WII PID.	21020			
	Registi	ar	FEB 26 2010 Several A. Sparket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Marylan	-	artment c tificate c				20	110	05579
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	uncate c	or Deatri		2. Date of Dear	leg. No. 🛴 🔾	IU	3. Time of Death
	Physicia		Edward	V.		Makowi	ecki			Month Februar	Dav	Year	6:00 a M
	Medic Examin		4a. Facility Name (if not institution,					n, or Location	of Death	repruar	~	y of Death	, 0.00 u
		•	Gilchrist Hosp	pice Cent	er			Tows	son			Balti	more
	Funeral		,	3. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs. la		If Under 1 You Months Da	ear If Unde	er 24 Hrş. Min.	8. Date of Birth (Month, Day,		9. Birthp Coun	nlace (State or Foreign
	Director		220-50-2780 Usual Residence of Decedent	1, A , W 2 🗀 1	6	Yrs.		,		August	13,194	8 M	aryland
	nd thow	ū	10a, State 10b. County		10c. City	y, Town or Loc	ation					1	0d. Inside City Limits
	laryla Ba-f s tified	Director	Md. Bai	Ltimore			Dunda	alk					1 Yes 2X No
	or 2	٥	10e. Street and Number				10f. Zip Cod				10g. Citizen of	What Coun	try?
	s 23a	Funeral	8192 N. Bound	dary Road	l			2122	22			USA	
	death item		11. Marital Status	Armed Fo		3. 13. V	Vas Decedent Yes, specify C	of Hispanic O Cuban, Mexica	rigin? (Spec an, Puerto f	cify Yes or No- Rican, etc.)		ce - Americ	
50	after	d by	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	e	1	☐ Yes 2X	No Specif	y:			y: Whi	
ş	hours natura ical E	Completed	15. Decedent		- 10	16a. Deced	ent's Usual Oc	cupation			16b. Kind of E	Business Inc	dustry
בב	in 72 e. nan "r	dmc	(Specify only highes Elementary/Seconday (0-12)	T			rind of work do O NOT use reti		st of workir	ng			
S S S T A TZ VCALS Z VCALS												S Bak	ery
Maryland	e filec ntal H ed ot	To Be	17. Father's Name (First, Middle, La Edward Makowie	•				18. Mot		(First, Middle, M n Neimcz		ne)	
Ĕ	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship	_		405 14-15-	- 4					Otata Zia C	
	12 shoulth an and 27 is		Sharon Makowie		life	1	-			Route Number, d , Dunda	-		
<u>ē</u>	and fee		20a. Method of Disposition			lace of Dispos	sition (Name o	f I		uary	20c. Location		
Ē	Page nent c ant: If Iry or		1 ☐ Burial 2※☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	3 ∐ Removal from ecify)	State	-	natory or other Cremat		26, 2		Baltim	ore, l	Maryland
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or of		21. St. natil e of Funeral Service Lic		-01	7 22	Name and Ad	dress of Faci	lity		Dundali	le D	7
11	ಹಿದ್ ತ ಕಾರ		Chillony	0/1	nell	y	7110 Sc	ollers	Point	Iome Of Road,	Dundal	k, Md	A• 21222
			23a. Part 1. Enter the disease or of shock, or heart failure. List or	omplications that ly one cause on,ea	caused the death ich line.	n. Pd not ente	r the mode of	dying, such as	s cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
7	nysician/ Medical	6 0	Immediate Cause (Final disease or condition resulting in death)	_ a EV	A STA	wen	N O	42971	<u> </u>			- 1	Onset and Death
	Examiner		rooding in addition	Dueto	(or as a consequence of the cons	ce of):	alvar	2 the					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	ience of):	00101	1	_				
_	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c									
)	exec ian ar irial-tr	E E	resulting in death) Last	Due to	or as a consequ	ence of):							
3	certificate be executed and ing physician and use as the burial-transit	dical		d									
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ZOZ	death ce he attene ed for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	Birth 2 Feta	death 3	Ectopic pregi Other (specif					ate of delive onth	Day Year
<u>.</u>	the de	Physician/Me	1 Yes 2 No 9 Unknown	g 🔲 Unk									
J.	that the		Part II. Other significant condition	s contributing to	eath but not kesi	ulting in the u	nderlying caus	e given in Par	t I.	23e. Did tol	bacco use con	tribute to th	e cause of death?
ds,	quires en sig ould b	ted	- Sassions as	1 ME (1)	rtom	9	5			1 🗆 Y	es 2 🗆 No	3 🗌 Prot	bably 4 🕅 Unknown
Vital Records,	law re las be 2 sho	Completed by	periperal	Vascu	ler of	store	cust	2 Can	und	24a. Was a autops	sy	prior to col	osy findings available mpletion of cause of
Ψ Υ	The I cate h		7 0					0 0	,	perfor 1 \(\superset\) Yes	med? 2 Xi No	death?	2 🗆 No
<u>ta</u>	ician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:				6. Place of De Other:			À-		1
<u>_</u>	Phys rthis eral di	<u>.</u> 10	27. Manner of Death	28a, Date		ER/Outpatien 28b. Time of	t 3 🗆 DOA	4 □ N Injury at		me 5 Reside	- (•		nospice
Division of	nding ath. :: Afte e fune	cat	1 Natural 5 Pending 2 Accident Investiga		th, Day, Year)	injury	١ ١	work? 1 □ Yes 2 □			,,		
<u> </u>	r Atte er de: rectol by th	Certificate:	3 Suicide 6 Could not 4 Homicide determine	28e. Place	of Injury - At ho	me, farm, stre	et, factory, off	ice	2	28f. Location (St City or Town		per or Rural	Route Number,
2	ital or urs aft ral Dir lled in	aC								,			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as to completed filled in by the funeral director, page 2.	edical	(Check 2 Medical Ex	Physician: To the base aminer: On the base	sis of examination	and/or invest	igation, in my c	pinion, death	occurred at	the time, date an	d place, and de	ue to the cau	use(s) and manner stated.
	fo the vithin of the comple	Σ	29b. Signature and title of certifier	Nurse Prantioner	To the best of my	r K. K. WILLIOGE . IC	00- 11-					1/11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	2 VI
	->-0		> Offican					158	30	3 1	Febru	My	242010
	A	N A	30. Name and address of person w	ho completed caus	se of death (Item	23a) (Type, P	rint)	10,	/	.0 -		/	24 2010 no
	1		HYMUN) C	MINOUN	S /VV	161	U/ /V	· W	WILL	7 25	19025	U/V /	vu)
	Stat Registra		31. Date filed (Month, PEB 2	6 2010	trar's Signat	ure J.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death W 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Miller, William Physician/ William E. Miller 20 Year 6:00 AM bruary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Poir Cecz VAMPRILAND HEALTH CARE SYSTEM erry 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, 1 uly 20 Year 213-20-8683 84 Director Maryland Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford County Abingdon Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code PLY STUBARY 10g. Citizen of What Country? Funeral 21009 United States 403 Denton Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use r [red]) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+)
N/A (NOW J. to Elementary/Seconday (0-12) Construction 12 Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Easter Bush William E. Miller, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Helen M. Miller (Spouse) 403 Denton Way, Abingdon, Maryland 21009 Baltimore, NAME 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Honor (Specify) Forest Hill, Maryland Evans Funeral Chapel 02/25/2010 Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—BelAir celm D 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, disease or condition UNKNOW nal Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2.20 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending hours after death Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 042800 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 Thomas Broado M.D. VA MARYLAND HEALTH CARE SYSTEM PERRY POINT MO 21902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** February 24, 2010 6:30 Aida ${ t Mitchell}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7809 Mandan Road Prince George's Apt. 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🛛 F 85 **Director** 185-16-0256 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a or 20770 7809 Mandan Road Apt. T-3U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status l allu canconerational Hygiene.
Health and Mental Hygiene.
The marked other than "natural", or Item
The marked other than "natural", or Item
The Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Secretary Mining 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Maria Giarusso (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important; If item 27 is any injury or other trau once. 25234 Vista Rd., Hollywood, MD 20636 Francis Mitchell (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 Other (Specify) Jefferson Memorial 2/27/10 Pittsburgh, pA 21. Sign nure of Juneral Service Lipinse 22. Name and Address of Facility Jefferson Memorial Funeral Home 301 Curry Hollow Road, Pittsburgh, PA 15236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erten /Medical Due to (or as a consequence of): Examiner bothy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗓 No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) after death.
I Director: After the in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

VV State Registrar

NARASIMHAM 32. Registrar's Signature

V

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26 2010

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SWA

2010

22576 McArthur Blvd.

Hollywood, MD 20619

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amend item 28 f. Department of Health and Mental Hygiene
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar 05582 Reg. No.Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0655 AM HILL MILES FEBURAT /Medical 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MEDICAL CENTER BALTIMORZ If Under 1 Year | If Under 24 Hrs. JOHNS HOPKINS BAY VIEW Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1**X** M 2 □ F Months Days Hours 215-66-3295 Maryland Director 05/27/1958 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exa. Inversigned at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 Middlesex Road U.S.A. 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Spence Miles Elizabeth Marie Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Miles (Son) 44 Blister Street, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard: 02/26/2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 EACH. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedian Cause (Final disease or condition resulting in death) Physician MOXIC BRAIN /Medical Due to (or as a consequence of): Examiner SMOKE INHALATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and burial-tran GENTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear Day 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown CHROMIC RZNAC Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural JEADKING 2 Accident FEBRUARY 192016 UNKNOWN 1 ☐ Yes 2 ☑ No ACLIBEATAL FIRE -CIGARETTE 6 □ Could not be 28f. Location (Street and Number or Rural Route Number 640 by or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Essex TE MIDDLESER RD. AT HOVINE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 125-000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTHONY LIN VENUE , BALTIMORZ EASTER 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINIAL

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Amend #17, per FH 8902 4/2/10 TT
State of Maryland Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2^y4, 2010 February Betty McMahan Jane 5:30 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F **Director** 179-18-3976 89 1920 Pennsylvania Usual Residence of Decedent ural", or items 23a or 28a-f shov I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Bethesda 1 Yes 2X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important, if item 27 is marked other than "-- any injury or other trauma**-Funeral 5906 Namakagan Road 20816 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: 3 🕅 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Assistant Private Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hochstatter ပ Martha Elizabeth Raabe Walter Greene Hochestatter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 Carousel Ct. Gaithersburg, MD 20877 Diane Marie McMahan (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Feb. Chesapeake Crematory 4 Donation 5 Other (Specify) Beltsville, MD 2010 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 24-48 hrs. Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1-2 Days Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury that initiated events 3-10 Days Diarrhea physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical 10-30 Days Autoimmune Gastritis P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 🕍 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practices: T. The sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices: T. The sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices: T. The sest of my knowledge, death occurred at the time, date and place at the cause (s) and manner stated. (Check 29c. License number 08660 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2/25/10 30. Name and address of person who completed clust of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd. Bethesda, Maryland 20814 Kimberly Zuzak, M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

FEB 26 2010

Momanan ozizu

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		rtment of H			giene Reg. No. 2010	05584			
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	e Myers	>	-		2. Date of De Month	ath Year	3. Time of Death			
L	Examir Funeral Director		4a. Facility Name (If not institution, gives COPPEN R (If 5. Social Security Number 212-20-9845	treet and number) 7. Age (In yrs. 85	**	4b. City, Town, or If Under 1 Year Months Days	Location of Death	8. Date of Birl	Ac. County of Dea	thplace (State or Foreign ountry)			
	D		Usual Residence of Decedent 10a. State 10b. County		y, Town or Loc	ation		Mar 2	24, 1924 M	aryland 10d. Inside City Limits			
	e Maryl Ba-f sho stified a	Director	MD Carroll		ykesvi					1 □Yes 2 No			
	with the la or 2 the no		10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	•			
36	be filed within 72 hours after death with the Maryland ttal Hygiene. 3d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	710 Obrecht Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	l If	21784 Vas Decedent of Hi Yes, specity Cuba □ Yes 2 № No		pecify Yes or No Pican, etc.)	United S 14. Race - Ame Black, Whi Specify:	erican Indian,			
21215-0036	within 72 hou ene. than "natura he Mediral E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occupa kind of work done o O NOT use retired	during most of wor)	king		b. Kind of Business/Industry			
	e filed vall Hygie other t	Be Co	12 17. Father's Name (<i>First, Middle, Last</i>)	<u> </u>	Res	taranteur		e (First, Middle,	Hospital Maiden Surname)	.1ty			
ylan	2 should be o and Mental is marked o raumatic eve	To B	Louis Seidenman				Helen	Weiler					
Maryland	12 sho hand∣ risma trauma		19a. Informant's Name/Relationship (Typ	· ·					er, City or Town, State,	Zip Code)			
ē,	permit. Pages 1 and 2 should by Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic evence.	1	Sally Long /Daugh 20a. Method of Disposition			HOOK ROS ition (Name of eatory or other place		Date	MD 21157 20c. Location - City or	Town, State			
m 0			1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	silloval floill State		atory or other place ke Crema	:	Feb 26,		le, Maryland			
Baltimore,	permit. Departr Importa any Inji		21. Signature of Funeral Service License		-	Name and Address Crematio	s of Facility Fun	eral Alt	ernatives Towson Mary	land 21286			
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the death e cause on each line.	1					Approximate Interval Between Onset and Death			
38760,	/Medical Examiner b bhysician and street burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or as a consequence of	uence of):								
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Records, P.	w requires that been signed be should be det	by	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the und	derlying cause give	en in Part I.	23e. Did to	obacco use contribute to Yes 2∐No 3□P	o the cause of death? robably 4 □Unknown			
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n o	ding Phys		27. Manper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			now injury occurred	ecny)			
Division or	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stre	M 1□Y	∕es 2□No		ocation (Street and Number or Rural Route Number, ity or Town, State)				
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Ų	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	Cu mp		29c. License number 29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>)							
			30. Name and address of person who con Wilbar Kuo	295 Stone	2 Ave	5+ 30	7 W	0 stmin	ste Me	0 21157			
	Sta Registr	-	31. Date fill FEB 26 2010	32. Registrar's agnat	facts	S							

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		1 - For State Registrar	State of	Marylan	_	artmen rtificate				ental Hy	•	2010	0.5	585	
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or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What	Country?		
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Baltimore, Maryland 21215-0036 permit. Pages and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is fluided Event scrings consist to other	To Be	Stephen Molna								Sonkol					
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Baltimore, oermit. Pages 1 ar Department of Hea Important: If item any injury or other once.		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nam	e of	-		ate	20c. Lo		or Town, State		
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Box 61 eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			l Ectopio pr	oananou					23d. Date of	delivery		
D. E dea	Sici	in the past 12 months? 1										Month	Day	Year	
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cord w requir	led	Myocardia		CHO	/					1 🗆 '	Yes 2	□ No 3□	Probably 4 🖺	Unknown	
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Division of Vital Records, to Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be did be did by the funeral director, page 2 should be did by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	Zee. Place of	Injury - At hor etc. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (S City or Tov	Street an	d Number or	Rural Route Nui	mber,	
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Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	Check only 2 Nedical Exa	hysician: To the be miner: On the basis	s of examinati	ledge, death on and/or inv	occurred a	at the tim	e, date an	d place, a	nd due to the	cause(s	and manner	as stated.	(s)	
the I hin 2 the I	led		and manner	stated.											
5 vit 5	=											I. Date signed (Month, Day, Year)			
1		30. Name and address of person who	completed cause o	f death (Item	23a) (Type, F	Print)	pp.	0.11	= 0 (+ 0	10 1 4	VININ	unn	12011	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, O. 1. O.

1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20,2010 11:53A™ Joseph C. Napolillo February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville 3006 Edgewood Avenue 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Min. Davs Hours 1**√** M 2□ F Maryland April 21,1926 83 Director 216-20-4522 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If a Medical Examinating must be notified at 1 ☐ Yes 2 No Director Parkville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 3006 Edgewood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify white Specify: <u>≨</u> 3 Wldowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Westinghouse College (1-4or 5+) Elementary/Secondary (0-12) Engineer Industrial 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mathilda Faulstich Gerard A. Napolillo, Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18705 Middletown Road-Parkton, Maryland 21120 Joseph G.Napolillo-son permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb.25,2010 Parkville, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 tool 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death TEPLOSCUERUTIL CARDIOVALCICAN Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2- No 3 Probably 4 Unknown certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 □Yes this certific al director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2☑No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? After 5 Pending investigation n 24 hours after death.

The Funeral Director: After the function is by the function in the function is the function in the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8713 HARPORD RD, BAL TOUND FAUSTO 0 istrar's Signature 31. Date filed (Month, Day, Year) Registrar

Wordelo, Fidel 2-19-10 0400 MP# 20577
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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	1	For State Registrar				•		of Death			Reg. No!	2010	05587
Physiciar	_	1. Decedent's Name (First,		_						2. Date of Dea Month	Day	Year	3. Time of Death
Medica Examine	al .	Fidel Anton 4a. Facility Name (if not insi			ber)		4b, City, To	wn, or Location	of Death	<u>Februa</u>		2010 County of Death	4:00 A ^M
		Gilchrist			,			wson				Baltimor	
Funeral		5. Social Security Number	6. Sex	M 2 □ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Months	Year If Unde Days Hours	er 24 Hrs. Min.	8. Date of Birt (Month, Day 5/19/			
Director	ŀ	261-72-8986 Usual Residence of Decede	ent		76_					2/19/	33	<u> </u>	
yland -f sho ed at	g		County		10c. Cit	y, Town or Lo						1	10d. Inside City Limits 1 Yes 2 No
or 28a	Dire	MD B	<u>Baltimor</u>	e		В	altimo				10g. Citi	zen of What Cou	
with the s 23a c	Funeral Director	5020 Spring	house C	r.				21237	7		J	USA	
death items		11. Marital Status		Armed For	dent Ever in U.S	S. 13. \	Was Deceder f Yes, specify	nt of Hispanic O	rigin? (Spe an, Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ameri Black, White	
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ld be f Menta arked atic e	욘	Francisco	Nordel	0		,		Ma	aria J	Jacob <u>a</u> I	Rodri	iguez	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Re	, , , , ,			A						Town, State, Zip	
f Healt f Healt item 2 other		Mr. Jose F. 20a. Method of Disposition	1			Place of Dispo	sition (Name	of		Date		dia 3282 cation - City or	
Page nent o ant: If ury or		1 Burial 2 Crer 4 Donation 5 0	nation 3 Re Other (Specify)	moval from	State	emetery, crer nape1 H	-	er place)	2/2	4/10	0r	lando, l	Flordia
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00 = 00	-	23a. Part 1. Enter the dise shock, or heart failure	ase, or comple	ations that o	caused the deal	th. Do not ente	er the mode	ilkens <i>I</i> of dving, such a	Ave. as cardiac c	Baltim or respiratory an	ore,	Maryla	nd 21229 Approximate
Physician/		Immediate Cause (Final	e. List only one	cause on ea	ich line.	h an							Interval Between Inset and Death
Medical		disease or condition resulting in death)	a .	Due to	or a conseq	uence of):	1	eym	**!(-			1	Jans
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The la										1 Yes	ormed? 2 X No	death? 1 ☐ Yes	2 🗆 No
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10		30. Name and address of			se of death (Iter	m 23a) (Type,	Print)	Clant	2 3	Cr Do	NEN	v mo	
Stat	e	31. Date filed (Month, Day,	Year)	MLES 32. F	Registrar's Sign	ture -	40 D	WALL		1 101	4 - 0//		
Registra	ar	FEB 2	6 2010	Sens	m B	A COL	NO.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 3. Time of Death Z 38 PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20010 Februar Nellie Beatrice Osborne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glen Burnie Anne Arundel Baltimore Washington Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Hours Months 05-09-1927 Country) **Maine** Director 82 004-20-3766 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🕅 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1453 Washington Avenue 21144 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 U. S. Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna May Libby Charles W. Douglass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1453 Washington Avenue Severn, Maryland 21144 Mark J. Osborne / Son Baltimore, 20b. Place of Disposition (Name of cemetary, crematory of other place)
National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 03-05-2010 Arlington, Virginia /Funeral Service Leen se 22. Name and Address of Facility Donaldson Funeral Home & Crematory, 1411 Annapolis Road Odenton, Maryla Sign Jure Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate hock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final On ancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 4 🗂 Unknown 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗷 No Hospital or Attending Physician: The 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Many r of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) FEB 26

Sborne

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

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urnie,

20161

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 4:06 AM 2010 senevieve 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltmore If Under 1 Year If Under 24 Hrs. Asnes 8. Date of Birth (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 🕇 Days Hours Min. 315-42-324¹¹ Usual Residence of Decedent Yrs Director Feb 25. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 31238 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Nidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, If a Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Domesti ememaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be eitz Annie ပ္ August 19a, Inform nt's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore M 20c. Location - City or Town, State 106 Sherring ouct 2mith 1 daughter IGNOCL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Crematory etro 21. Signature Friend Service Licens 22. Name and Address Lility 1 Dr. Jessup, PA18434 tM 1233 Midvalley 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock, or heart failure. List only one cause on each line.

Immediat J cause (Final disease in condition resulting in death)

a. Atteroscience of:

Due to for as a consequence of: A proximate Interval Between Onset and Death Physician Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No this certificate 1 ☐ Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Lebrary 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimory. DOUTH Caton

State Registrar 31. Date filed (Month, Day, Year)

32. Regist ar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4:00_{a M} Day Month Year **Physician** James H. Pyke 18, 2010 Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Asbury Methodist Village Gaithersburg 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F China 7/1/1915 94 Director 719-18-5364 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Gaithersburg MD Montgomery Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20877 USA 301 Russell Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seminary Professor permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, Its once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances L. Taft Frederick M. Pyke ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6003 Wilmett Ave. Bethesda, MD 20817 Elizabeth R. Pyke, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/23/2010 Rockville, MD Parklawn Cemetery 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Seption Licensee 933 Gist Ave. Silver Spring, MD 20910 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Cementiz **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bematon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a co CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician: The law requires that the death certificate be executed burial-trar the attending physician and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1K Yes 27 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation vatural Multiple falls 2 X Accident 2008 Unknown M 1 □Yes 2 X No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 301 Russell Avenue filled in by 4 Homicide Home Gaithersburg, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertilier 29c. License number o completed cause of death (Item 23a) (Type, Pri 30. Name and address of perso Ave. Gaithersburg Md MD Ò inska 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

FEB 25 2010

10-01583 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Reg. No. T. Decedent's Name (First, Middle,Last)
Kristin Danielle Passauer Physician/ 2. Date of Death 3. Time of Death Month Day February 22, 2010 Medical Examiner 0831 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3101 4 Seasons Court B2 Dundalk **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Director Min. Hours 214-08-7427 25 9-5-1984 Country) MD 1 M 2X F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Co MD 1 Yes 2 X No Dundalk with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 Four Seasons Ct. 21222 Apt B2 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, permit. Pages I and 2 should be filed within 72 hours after death v Opparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item nijury or other traumatic event, the Medical Examiner must b Armed Forces? 1 X Never Married 2 White, etc. 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ₹ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 N/AStorage Consultant Storage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Raymond Passauer, Jr. Stephanie Lable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)? 1 2 2 2 Stephanie Passauer-Mother 3101 Four Seasons Ct. Apt. B2 Dundalk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify 2-27-1010 Bayview Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Between Onset and Death Immediate Cause (Final disease Methadone intexication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical X UNPENDED AMENDED #1,23a,27,28a-f,permE, g901 3/9/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 V Live birth Ectopic pregnancy Fetal death Month past 12 months? Day Year Pregnant at time of death 5 Other (Specify) Aug 28, 2009 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Pending 1 Yes 2 No Fd 2/22/10 Fd 8:23 am 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State 3101 4 Seasons Ct B2 Dundalk, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide found at home determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 23, 2010

State Registrar

32. Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Month, Day Year) FEB 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05592 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2. 25^{Day} **Physician** 2010 Ida Pasley Josephine 12:06A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace Months Days Hours Min. 9, 11, 1919 9. Birthplace (State or Foreign Country)
N.C. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2√2 F 90 Director 212-50-6634 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examinar must be a confined at 1 ☐Yes 2 X No Directo Maryland | Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 USA 1906 Bruce Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Ida Caudill Jones B. Eller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Bruce Rd, Aberdeen, MD 21001 19a. Informant's Name/Relationship (Type. Print) Betty Bailes / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Memorial Gdns. 3/1/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 5 per 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COVOY Physician Discare avy 10 Um disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, the line to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 □Yes 2 ☑No 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performed certificate 1 □Yes 2 □No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Box 68760. P.0. Records. Viital Division of

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or Attending Physician: To the Hospital o within 24 hours af To the Funeral DI completely filled in

29b. Signature and title of certifier

3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one)

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05593 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year adys Purcell 1201C /Medical lity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1 □ M 2 💢 F Director 578-40-2986 17,1928 Tennessee Sept. Usual Residence of Decedent within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Even intermist be notified at Director 1 □Yes 2 No Glen Burnie Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 United States Funeral 7900 Benesch Circle #826 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates; 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: 3 ☐ Widowed 4 🂢 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elkridge, MD 21075 6615 Devlon Pl. Nancy Warren / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State Feb. 26, 2010 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Fineral Service 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 013 Glen Burnie, MD 21061 421 Crain Hwy. SE; 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** art Faill disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinitellate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe Yes 2 certificate 2 🗆 No 1 ∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death | Director; A | d in by the f 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

P.O. Box 68760, Records, of Vital Division

n 24 hour. the Funeral Dire completely within 2

> State Registrar

29b. Signature

30. Name and address of p

FEB 26 201

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eath (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 ear 11:45 P M Bertha E. Patterson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7982 Mackintosh Dale Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F 7411-1920 203-07-3352 Director 89 Yrs Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at be filed within 72 hours after death with the Maryland Director Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 21061 7982 Mackintosh Dale IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. or Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 □ Divorced Specify: white Year or Dates item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Home maker Home Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roy M. Umberger Bertha Miriam Sprenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Russell Patterson/son 7982 Mackintosh Dale, Glen Burnie MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2/25/2010 Catonsville, MD 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA Signature of Piperal Service Licer M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Director: After 1 I in by the funera 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of cer 29c. License number 2010 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 10 2010 0810 M Physician/ WILLIAM LEE PRICE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 9. Bemplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Sex. 1 M M 2 □ F Funeral Month, Day, Yea 21/1965 WEST VIRGINIA Months 232-21-0616 44 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Director 1 Yes 2 □ No BERKELEY MARTINSBURG WV 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 25401 211 SENTRY LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by WHITE Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: 3 Divorced 16b. Kind of Business Industry EASTERN PANHANDLE 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) SORTER Elementary/Seconday (0-12) TRAINING CENTER College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ GARY GLENVILLE PRICE DORIS MARVEEN ROBERTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 211 SENTRY LANE, MARTINSBURG, WV 25401 DORIS MARVEEN PRICE/MOTHER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition I5. FEB. cemetery, crematory or other plants SMITHSBURG CREMATORY 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG, MD 2010 lame and Address of Facility BROWN FUNERAL HOME 327 W. KING ST., MARTINSBURG, WV 254 22. Name and Address of Facility PO BOX 821, 21. Signature of Funeral Service Licensee WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) ⁴Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown -ome Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ral director, page 2 performed? 2 No 2 1 1 Yes Yes 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical examiner? Other: 2 No 1 Yes 1 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ within 24 hours after oeau..

To the Funeral Director: After th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury Matural Natural 5 Pending work?
1 Yes 2 No М Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 06973 MEER SANKOMMU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willow 2500

DHMH 17 Rev 7/2009

State

Registrar

. Date filed (Month, Day,

FEB 26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB. Physician/ Day PLOWMAN ARKE 12:53 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE HUSPICE GILCHRIST UWSON 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Hours Jan 27, Year 1927 Director 220-20-4710 83 Vrs Maryland Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Cockeysville 1 Yes 2 X No Md. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21030 12115 Boxer Hill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Television Supervisor should be filed with n and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Μ. Benson Elsa Parke Plowman, Sr. Ross injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Mrs. Suzanne Plowman / Wife 12115 Boxer Hill Rd. Cockeysville, Md. 21030 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wiseburg Cemetery 2-26-10 White Hall, Md. 22. Name and Address of Facility Son Funeral Home, 21. Signature of Faneral Sa 1050 York Rd. Towson, Md. 23a. Part 1. Inter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEEKS Immediate Cause (Final Physician/ ENEBROVASCULAR disease or condition Medical resulting in death) Examiner SYSTEM CENTRA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has }; page 2 s performed? Yes 2 No Hospital or Attending Physician: The this certificate 2 🗆 No 1 🗀 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2X No Other: INPATIENT HOSPICE 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 P Other (Specify To the Hospital or Auconomition 24 hours after death.

To the Funeral Director: After this manufacted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10+1 State

only one) 29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

FEB 26 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHEN

Registrar DHMH 17 Rev 7/2009 BOX

57444

FEB

Towson

2010

21284

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pautenis February Anna R. 22 2010 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗓 F Days Hours Min. Months 214-01-4942 94 Mary and Director T915 Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c, City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2420 Autumn Wav 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ရ Santo Caminiti Mary Azzaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Mr. John O'Brien/ Caregiver 2420 Autumn Way Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2-26-10 Most Holv Redeemer Baltimore, Md. 22. Name and Ruck Frowson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Dementia Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 24 hours after death.

• Funeral Director. After this certificate has been signed by the atte eted filled in by the funeral director, page 2 should be detached for a Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy PAUTENIS death? 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fi (Check 3 🛮 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/23/2010

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signatur

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIFER HAUF, CRNP

26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G901, 3/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death February 24, 2010 Physician/ Louis E. Queral 2:05A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist 5. Special Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 **X** M 2 □ F Months Hours Puerto Padre 1271871921 Director 202-40-8590 88 Yrs Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore Towson MD 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? 205 E. Joppa Road Funeral USA 21286 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit, Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 Specify: White 1 X Yes 2 □ No Specify: Cuban 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Surgery Surgeon other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luis F. Queral Ana C. Gonzalez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8536 Hill Spring Drive Lutherville, MD 21093 Eva Queral Fiastro / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/27/2010 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Druid Ridge Maus. injury 4 □ Donation 5 □ Other (Specify Entombment Towson, Maryland 21204 Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) uss Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Yes 2 No the a 1 Urknown Division of Vital Records, P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 3 Probably 4 ☐ Unknown Completed I 2 🗌 No 1 Yes iis certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 31. Date filed (Month, Day, Year) **FEB 2 6 2010** State

DHMH 17 Rev 7/2009

Registrar

10-01552	Please Type or Print in Black Indelible Ink. Ensure All C	opies Are
Kenneth John Riefner	State of Maryland / Department of Health and Men	•
1- For State Registrar	Certificate of Death	
Physician/ 1. Decedent	t's Name (First, Middle,Last)	2. Date of Month
**adical Examiner	Kenneth John Diefner	Februs

2010 0559

		1- For State Registrar		Certi	ficate of	Death			Reg	J. No.	10 0333	-
Physici		Decedent's Name (First, Middl	e,Last)						Date of Death	Day Vaar	3. Time of Death	Τ
"adical Exam	iner	Kenr	neth Joh	n Riefn	er				Month February 20	Day Year 0, 2010	1642 hrs	
		4a. Facility Name (if not institutio				b. City, Town, or	Location of I	Death		4c. County of	Death	_
		8701 Maravoss Lane				Parkville				Baltimore	County	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 2	24Hrs. 8	B. Date of Birth		9. Birthplace (State or	_
Director		212-88-6419	1 X M 2 F		10 v	Months Days	Hours	Min.	Cont	6 1961	Foreign Country) Maryland	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	.0	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (Street	and Numbe	er or Rura	al Route Numb	er, City or Town,	State, Zip Code)	_
; MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eatht and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once		Warren Riefne	er/ Brot	her	7848 T	<i>J</i> ermon Av	enue	, Ba	Limor	e, Maryla	and 21234	
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		20a. Method of Disposition		20b. Pla	ce of Disposit	ion (Name of cen	netery,	D	ate	20c. Location - C	ity or Town, State	_
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Pag ment tant:		4 Donation 5 Other Sp		Bvu	Bel Aii							_
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		21 Signature of Funeral Service	Li see		Eval	ame and Address	of Facility Cha	apel	& Cre	emation Ser	rvices	
E. E A B		JULIJULI	LILLY		18800) Harford	Road	d, P	akvil	le, Maryla	and 21234	
Physician	7	23a. Fart I. Errer the disease, or failure. List only one cause		aused the death. D	o not enter the	e mode of dying,	such as card	diac or re	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and	
/Medical Examiner		mmediate Cause (Final disease		sclerotio	Cardi	ovascu1a	ar Dis	ease	<u>r</u>		Death	
LABITITIES	1	or condition resulting in death) Due to (or as a consequence of):										
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30x	Physicial	1 Yes 2 No 9 Unk	nown 9 Unkn	own	o Our	er (opodiy)						
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300		30 Name and address of person	· ·									
Ot 5,		Margarita Korell MD.		dical Examiner		nn Street, Ba	altimore, i	MD 212	201			
S	tate	31. Date filed (Month, Day, Year)		egistrar's Signature	par	Kal						
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Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Donald Rice W_ 18, February 2010 1155 p. ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-22-0842 1**X**M 2□ F 82 MD Director 07/08/1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examinant must be notified at Director 1 ☐ Yes 2X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3510 Forestedge Drive Apt. 2A 20906 USA Funeral or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. within 72 hours after 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White þ 3 Widowed 4 □ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Broadcast Engineer Radio Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Lewis William Rice Madeline Elizabeth Shelton ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Jean Rice Kerns, Daughter 18000 Fence Post Ct., Gaithersburg, MD 20877 Department of Health Important: If item 27 any Injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 02/22/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation 933 Gist Avenue, Silver Spring, MD 20910 Svcs. Merry Avant per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner the death certificate be executed Exami OVONAL and use as the burial-trai resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 Other (specify) o the detached 1 Yes 2 No 9 Unknown þ ۵ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Man of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending s after death. 1 🗌 Yes 2 🗆 No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ince Philip Headher 32 Registrar's Signatu 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
Shirley Mae 2. Date of Death ²0,20 10 Reynolds February 12:10 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Baltimore 2812 Maudlin Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 20, 19 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In vrs. last birthday 1 □ M 2XXF 77 1932 218-26-8017 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No N/A Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21230 2812 Maudlin Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🛣 No Specify: White Specify: 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Katherine Tilghman William E. Grine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Albright (Daughter) 303 Orchard Road Glen Burnie, Maryland 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Buria 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 2/24/10 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility L. Kaufman Funeral Home at MMP Washington Blvd. Elkridge, MD 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Ovariam 23d Date of delivery 23b. Was decedent pregnant yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a Was an

Physician /Medical **Examiner**

attending physician and for use as the burial-trar

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within 24 hours after death

To the Funeral Director:
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Completed

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Certification: To

Medical

that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital Hospital or Attending Physician: Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If item 27 is marked other than Iry or other traumatic event, I'm. III

Department of Health ar Important: If item 27 is any injury or other trau

Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

se. Enter Underlying use (Disease or injury initiated events	· diabetes	melli
ulting in death) Last	Due to (or as a consequence of):	
EMALE:		

1 □Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 ☐ Pending investigation

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural 2 ☐ Accident

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 Maidenchoice Lane Ste 205

Sten E Johnson MD Bactimore, Md 21228

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year) FEB 26 2010

32. Registrar's Signature

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	Examin		4a. Facility Name (If not institution 6386 Loudon A		ımber)		4b. City, Town,		of Death		4c.		
		X.	5. Social Security Number	6. Sex	7 Age	(In yrs. last birthda		idge	24 Hrs. p	B. Date of Bir	th	Howard	thplace (State or Foreign
· ·	Funeral Director		213-20-4433	1 ⊠ M 2□F		83 Yrs.	Months Days		Min.	(Month, Da	19. Year)	Co	ginia
	p ,		Usual Residence of Decedent										
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Ind	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Heatth and Mental Hygiene. If Item 23 or 28a-1 show if Item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Executing must be nutified at	Be	17. Father's Name (First, Middle	, Last)						First, Middle, hiffle		Sumame)	
3		2	Noah Raines	chin (Tuna Print)		10h Ma	iling Address (Street					r Tourn State	Zin Code)
Z a	od 2 s lith an 27 ie 1 traui		19a. Informant's Name/Relationship (Type, Print) Danny L. Raines - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Son) 6109 Yeagerstown Rd., New Market, MD										.774
ē,	f Hea f Hea ltem		20a. Method of Disposition			20b. Place of Dis	position (Name of rematory or other pla		Da			cation - City or	
E	Page nent c ant: H ary or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State	Atlantic	Cremator	cy O				Burnie	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other tra once.		21. Signature of Funeral Service	censee	0				_				al Home at
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B	e deal	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 32e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red II 25e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppose in Red I. 23e. Did to the underking suppo									Month	Day Year	
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-			30. Name and address of person	n who completed cau	ise of dea	ath (Item 23a) (Typ	e, Print)	BACK	way	-h 30;	ŝ. (dut	eq. MD 2104
20	Sta	te	31. Date filed (Month, Day, Yea			's Signature			·				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB Month Physician/ Michael W. Smith 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1207 Whitman Dr. 1956 Glen Burnie 8. Date of Birth (Month, Day, Year) 11–14–1956 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours 1 🔀 M 2 🗆 F 53 Director 214-64-7464 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Anne Arundel MD Glen Burnie 1 🗌 Yes 2 💢 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 1207 Whitman Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1XXNever Married 2 Married Completed by 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: and Mental Hygiene. Specify: White 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Shipping / Receiving College (1-4 or 5+) Fork Lift Operator Be 18. Mother's Name (First, Middle, Maiden Surname)
Alice R. Martin 17. Father's Name (First, Middle, Last) ည Richard Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1207 Whitman Dr., Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type, Print)

Lawrence K. Smith / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State 03/02/2010 Odenton, MD W. Arundel Crematory 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility
Bailey Funeral Home and Cremation Seriv
4023 Annapolis Road, Halethorpe, MD 212 Maleite M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ncer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown P.O. 1 n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Pobably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rnis certificate has b il director, page 2 sh autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2/ DNO ρ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinating end/or investigation in my calcium, date. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioned: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and D1858 31. Date filed (Month, Day, Year) State FEB 26 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of 26/2010 and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Migldle, Last) Month Physician 05 2010 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. Coupty of Death Examiner NUV514 OVICA 0/4kgS Okst If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 25,1935 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**⊠**M 2□F South Dakota 74 Director 503-30-3960 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director Dayton Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 U.S.A. 21036 13839 Dayton Meadows Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Black, White, etc. 1 X Yes 2 No Army If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. <u>\$</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Civil Engineer Government traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fil h and Mental H 7 Is marked ott Be Florence Otto Benjamin Smeins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 Health 13839 Dayton Meadows Court Dayton, Maryland 21036 Dorothy Smeins (Wife) permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 2-15-2010 Hagerstown, Maryland 21. Signature of Funeral Service Licensee witzke funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 240 Caud /Medical Due to for as a consequence of): Examiner 10 m a Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CERTIFICATION ASPROVED BY MEDICAL EXAMINER law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1□Yes 2□No ned by the a 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes due to Spinal Stenosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has performed? /es 2 \ No 1∐ Yes 25. Was case referred to medical examiner?
1 X Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 1-X Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director; A
pletely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the To the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

(10)

State Registrar 31. Date filed (Month, Day, Year)

FEB 26 201

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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 25,27,28a-f per me,g900,02/25/2010dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Bertha Binkowski Simpson 11:30 PM 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner -ORIE KIVER If Under 24 H 8. Date of Birth (Month, Day, Year) 06/03/1919 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2KKF 90 218-07-1263 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating must be notified at Baltimore Director Maryland Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1000 Franklin Avenue, Apt. #210 21221 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimoré, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Michael Joseph Binkowski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Rogowski (Daughter) 3310 Dublin Manor Road, Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 02/24/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Europa Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immanate Cause (Final **Physician** discase or condition sulting in death) andin-Due to (or as a conseq rence of): /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examine law requires that the death certificate be executed ON APPROVED BY MEDICAL EXAMINER the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, physician attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed 1 ☐Yes 2 ☐ No 1 ∐ Yes 2 1 No funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month. Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Injury 2 Accident Subject fell investigation 01/12/2010 Unknown M 1 ☐ Yes 2 X No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1.23 Belcamp Garth Belcamp, MD 21017 ģ determined 4 Homicide Nursing Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed

DHMH 17 Rev 1/2001

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un 32. Registrar's Signature Vac Abail

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05606 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02-23-2010 **Physician** Alton Sulin 100 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hart Heritage Forest Hill Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 09-23-1924 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Min. Days Months 1 → M 2 □ F 85 204-16-9674 Ohio **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, it a Medical Exp. ingr must be notified at Director 1 ☐ Yes 2/☐ No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 D Canterbury Rd 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 ☐ No Baltimore, Maryland 21215-0036 1 □Yes 2 No \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed wn.

N Hygiene,

r than "r Elementary/Secondary (0-12) College (1-4or 5+) Teacher Balt. Co. Public School n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Matthew Sulin Anna C. Bzinak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Sulin (Wife) 302 D Canterbury Rd Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02-24-2010 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Se vice Licensee Drien -Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disense **Physician** Oransky 42A21 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Year 5 Other (specify) □Yes 2□No signed by the a 9 Ulnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cestive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 ☑No 1 □Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2. No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death E Funeral Director: in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the I within 2 To the I

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

W, MACPHAIL Bel AIN, MD 21014

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:45 A.M Andrew Senft 2010 February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel South River Rehabilitation Center Edgewater | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr. 29, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign · 1909 1 ★M 2 ☐ F 063-10-9498 100 Apr. Germany Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts Edgewater Anne Arundel 1 X Yes 2 □ No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number UNITED STATES 21037 444 Maple Leaf Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2**X**☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married 2X No 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waiter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margred Seubold Edward Senft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 444 Maple Leaf Dr. Edgewater, MD 21037 19a. Informant's Name/Relationship (Type. Print) Edward V. Senft/Son 20b. Place of Disposition (Name of George W. Samalo Unit Versel's Style Medical Center 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) ature of Funeral Service Lice 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 /M00969 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carchio vasculas diseas Htheroscierotic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 5 ☐ Other (specify) t Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertensive Heart 1 Yes 2 No 3 Probably 4 Unknown Hypothyroidism 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No Dementi 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

Completed by

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28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

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other traumatic event, the Medical

and Mental Hygiene. Is marked other than

item 27 i

Department of h Important: If iter any injury or oth

72 hours after

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transi signed by the a P.O. I signed by or Vital Records, page 2

IF FEMALE: 1 ☐ Yes

1 Natural

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

Physician/Medical Completed by Be ٩

Examiner

funeral Certification:

this certificate After death. al or Attend after death. filled in by the within 24 hours a To the Funeral I

Division

1

State Registrar

Medical

29b. Signature and title of certifier

6 Could not be

determined

Surana

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 50653

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2/2/2010

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 851 Deale Murchion

SURANA GYANI Rouch

31. Date filed (Month, Day, Year)

32. Registrar's Signature FEB 26 2010

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death February 23, 2010 Physician/ POLLICOVE SPAIN 4:45 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 10218 Bradly Lane Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Days June 7, 1926 Min Hours New York 577-32-5964 83 Director Usual Residence of Decedent 28a-f shov 10a State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Prince George's Laurel 1 Yes 2 XXVo 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 13500 Briarcroft Court 20708 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give þ 1 Never Married 2 Married filed within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural", 3 XWidowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than U.S.D.A. / Elementary/Seconday (0-12) Grade 12 College (1-4 or 5+) Secretary Federal Government Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is many injury or otherwise. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Pollicove Eva Goldberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Spain 10218 Bradly Lane Columbia, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date tXX Burial 2 Cremation 3 Removal from State 03/31/2010 Arlingotn Nat. Cem. Arlington, VA 4 Donation 5 Other (Specify) Signature of Euneral Service Licensee Bonaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hily one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between shock, or heart failure. List Immediate Cause (Final Paset and Death Pnysician Large B Cell Lymphoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner IgM. Waldenstroms Macroglobulinemia 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 XXInknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe To the Hospital or Attending Physician: The After this certificate 2 **XX**IO Yes 2XXV 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Son's examiner? 2 **XX**00 Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 XX Natural Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur, 29c. License number 29d. Date signed (Month, Day, Year) D 25430 February 24, 2010 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) John Margolis, M.D. 13952 Baltimore Avenue Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indellible Ink, Figure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 1 1

			for State Registrar	State of Maryland /	Department of r Certificate of		, ,		
			Decedent's Name (First, Middle, Last	ot)	001111100110 01		Reg. I	ZU U	3. Time of Death
	Physici /Medio			Thomas Schmith		Fe	b. 23, 2	2010 Year	6:30 PM
1	Examir		4a. Facility Name (If not institution, give			r Location of Death	4	c. County of Death	
*			1720 Deths Ford R			de Grace	Data of Dinth	Harfo	
	Funeral Director		039-22-9004	ex 7. Age (In yrs. last bi	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Yea b. 28, 1	1934 Rhode	lace (State or Foreign try) Island
	and sw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			11	0d. Inside City Limits
	Maryl -fsho	tor	Md. Har	ford	Ц	avre de Gra			1 ☐ Yes 2 🛣 No
	h the	irec	10e. Street and Number Ford	1014	10f. Zip Code	uvie de die		Citizen of What Coun	try?
	23a c	ral	1720 Deths Foed R	oad		21078		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modeal Evair, in a file in tilling at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ Nol 958 — If Yes, Give Ye ar or Dates: 1978	13. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ☑ No	Hispanic Origin? (Specifian, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Americ Black, White, 6 Specify:	
21215-0036	2 hou latura ical E	ted	15. Decedent's Ed	ucation 16a	. Decedent's Usual Occup	pation	16b.	Kind of Business/Inc	
218	ithin 7 ne. nan "n	Completed	(Specify only highest gra	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d)			
	led will her ther ther ther there is a second to the there is		47 Fallenia Nama (First Middle Loot)	5+	<u>ieutenant C</u>	olonel 18. Mother's Name (F	Vent Adiable Adela	<u>Militar</u>	У
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, In	To Be	17. Father's Name (First, Middle, Last) Albert	Schmith		16. Wothers Name (F		Connell	
ary	should and Men s marke	-	19a. Informant's Name/Relationship (Type. Print) 19t	o. Mailing Address (Street	and Number or Rural R			Code)
	1 and 2 Health a em 27 is		Mrs. Joanne Schmit		720 Deths Fo				
Baltimore,	Pages 1 nent of H int: If iter		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	of Disposition (Name of ery, crematory or other place	ce) Date	20c.	Location - City or To	wn, State
Ιŧπ	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify	/ [731 1 1 13]	gton Nationa	1 Cem. 5/3/	<u>'10 Arl</u>	ington, V	<u>irginia</u>
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	1 Dund	1050 York	ess of Facility Ruck Road Towso		uneral Ho and 21204	me, Inc.
	Physician /Medical		23a. Part 1. Enter the disease, or only shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	" 5677145	not enter the mode of dyl	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b. Due to (or as a consequence	- Live	r 2"	see Le		
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C					
90,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence	of):				
68760,	icate physi s the b	edical		d					
O. Box (The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ру		23d. Date of delive Month	ery Day Year
σ.	that the		Part II. Other significant conditions of	ontributing to death but not resulting i	n the underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
rds	w requires t been signers should be	ed by			· -		1 🗆 Yes	2 (∑/N o 3 ☐ Prob	ably 4 🗌 Unknown
Vital Records,	. The law re cate has bee page 2 sho	Completed					24a. Was an autopsy performed?	? death?	psy findings available inpletion of cause of
/ita	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death (C	•		
of \	Physician: r this certifica ral director, p	ို	1 Tes 2 17 No	Hospital: 1 Inpatient 2 ER/O		4 Li Nuising Home		6 ☐ Other (Specify	y)
	ng ifte	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Time of 28c, Injui Injury Wor M 1 □	ry at k? Yes 2 □ No	. Describe how in	jury occurred	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f.	Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	he Hospit n 24 hour ne Funera pletely filli	Medical (29a. Certifier (Check only one)	yslcian: To the best of my knowledg niner: On the basis of examination a and manner stated.	e, death occurred at the tind/or investigation, in my o	me, date and place, and opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	\ 0	29c. Licens	se number		Date signed (Month, 1	Day, Year)
	0 1		, lm	12 my	177	1654		154110	
(110	6,	30. Name and address of person who		(Type, Print)	- RIGIT	\ m_ M/	\h. a	21201
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year mes FEBRUARY () 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 24 Hrs. Social Security Number If Under 1 Year Months Days Age (In yrs last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 64 Days **Director** Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Marylanc 10b. County 10a, State 28a-f show 10c. City. Town or Location 10d. Inside City Limits Funeral Director Examiner must be notified 1XYes 2 ☐ No timore 10e. Street and Nug 10f. Zip-Code ō 10g. Citizen of What Country? 2121 23a Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 🗌 No ö þ 1 ☐ Yes 2 🐪 No Specify: 3 Widowed 4 Divorced Blac "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than "I event, the Med Colleg (1-4 or 5+) Elementary/Secondary (0-12) erk Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle and Mental F ပ္ Saskin traumatic ra Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, of Health a liams or other 21078 20a. Method of Disposition 20b. Place of Disposition (Name cemetery, crematory or the permit. Pages
Department of Important: if it
any Injury or of once. 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License al Gervices 23a. Part 1. Enter Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or healt-failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** SMALL DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death Month Yes 2 No 5 Other (specify) Day Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 🗌 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 22 No or Attending Physician: 1 Yes 25. Was case referred to medical Be examiner? 26. Place of Death (Check only one) 2 / No ည 1 🗷 Inpatient Other: 2 ER/Outpatient After this 3 🗌 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury Director: A d in by the f 2 Accident 1 🗌 Yes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M.D FEBRUARY, 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 RAJANI JAGANA 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State Registrar's Signa Registrar

DHMH 17 Rev 1/2001

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Physici		Registrar Reg. No.	e of Death						
Physicia Medical Exami		Month Day Year	0 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_						
1		3424 Mary Avenue Apt. B Baltimore							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Foreign	1						
Director		107-42-4250 1 M 2 XF 5' 1 Yrs. 6-28-1432 Country)	J·Y·						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In:	side City Limits						
* .	ايا	Baltimore	Yes 2 No						
faryla 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							
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t be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American India White, etc.	an, Black,						
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MD 2 d 2 shoul tth and M n 27 is m numatic	To	19a. Informant's Name/Relationship (Type Prift) aug I ter) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Cook 2706 Reese, St. Balto MD 2110	ie)						
ra mar		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, S	taté						
Baltimore Dermit. Pages 1: S Department of H. Important: If it		1 Burial 2 Cremation 3 Removal from State crematory or other place)	MI						
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Physician			en Onset and						
/Medical Examiner		Immediate Cause (Final disease a. Morphine intoxication	Death						
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Box 68760, s death certificate be the attending physic of for use as the bur	an/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year						
lox 687 leath certific e attending for use as t	/sici	1 Yes 2 No 9 ✓ Unknown							
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Division of Vital Records, P.O ral or Attending Physician: The law requires that trs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detax	ē	1 Yes 2 No 3 Probably 4	✓ Unknown						
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ion of tending Pheath.		27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred							
ion ttendi leath. tor: /	Certification:	1 Natural 5 Pending Fd 2/18/10 Fd 7:30 pm 1 Yes 2 X No unk							
Divisipital or At ours after deral Direct filled in by	tific	3 Suicide 6 Could not be determined determined determined (Specify) house 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Balt Immorphism) 4 Mary Ave Balt Immorphism (Specify) house	Number City e Apt E						
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To the Hos within 24 h To the Fun completely	ica	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	s)						
To the within 7 To the complet	Medical	and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day,							
		O.C.M.E. February 19, 2010	, ,						
d		30. Name and address of person who completed cause of death (Item 23a)							
Y		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
S									
Renist									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 26 per doc g900 2-26-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Shorb 09, Jean. Amelia February 2010 4:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Tate House, 817 Camp Meade Road #E Linthicum Heights Anne Arundel If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Months Days Hours Min. 12-13-1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 F Washington DC 579-40-8111 77 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural" ~ " any injury or other traumatic events." 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits Director 1 ☐ Yes 2 X No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5945 Abrianna Way-E 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. Completed by Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Seifert ပ Bertha Augusta Krause 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa J. Haney - Daughter 6601 Hunter Road, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Wash. Nat'1. Cem. 02-20-2010 | Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerul Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast CANCEL Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): o the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Tyes 2 TNo 3 TProbably 4 Tronknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 □Yes 2 🗷 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home Statesidence 6 MOther (Specify) hospice 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Japital C.
4 hours after dea.
77 | Director: After 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37013

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

ORIGINAL

11055 Little Potyert Pkny Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Parar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 21, Physician 2010 6:20 P M McCellen Shore Harry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1800 Harman Avenue Baltimore 8. Date of Birth (Month, Day, Year) 03-22-1939 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 52 M 2 □ F Pennsylvania 70 Director 217-34-6143 Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Wedfoal Examinar must be notified at Director XXYes 2 □ No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1800 Harman Avenue 21230 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1961 1 ☐Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White Year or Dates 1988 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withii Health and Mental Hygiene. em 27 Is marked other than 12 warehouseman Liquor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva Mary Price Paul Steven Shore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 Harman Avenue, Baltimore, Maryland 21230 Sue Shore - wife Department of Health Important; If item 27 any injury or other the once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation □ □ 21. Signature of Funeral Service Licensee MD Veterans Cemetery 03-02-2010 Crownsville, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End S+ a Due to (or as a consequence f): disease or condition resulting in death) /Medical Examiner Diabetes Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed orong and burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐ No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 performed 1 □ Yes 1 ☐ Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2-25-2010 038747 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beh MO 516N Rolling Re Svite 107 26 201 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 2010 Month PM M Physician Alice Delores Stamper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Courtland Gardens Nursing Home Pikesville Baltimore | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months Days | Hours | Min. 3-12-1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Vear) 1□M 21 F MD 216-24-9587 77 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits works 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Randallstown Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9825 Southall Road 21133 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify. African-American 1 ☐ Yes 2 →No 3altimore, Maryland 21215-0036 \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Housing Authority 12th h and Mental Hygier <u>Admininstration</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Stamper ပ Pauline Alston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trae Muriel Stamper/Daughter 9825 Southall Road, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3-1-2010 Woodlawn, MD Signature of Foneral Service Licenses 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, 9 Im ediate ause (Final dise condition resulting in death) Physician 6 morth Coriner /Medical Due to (or as a consequence of Examiner wens Sequentially list conditions, any admits a limit of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) P.O. Box 68760,5 signed by the attending physician I be detached for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy perform certificate 1☐ Yes 2 25. Was case referred to medical examiner?: Be 26. Place of Death (Check only one 2 No Other: Amursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P .fre Hospital or Atte...thin 24 hours after death...
> Funeral Director; After thir funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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30. Name and address of persen who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 0561 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 25, 2010 Morton Sturt 1:10 a. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Ap (Manth, D2)7 Year) 1917 Director 318-18-6463 92 Illinois Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Chevy Chase 1 🗆 Yes 2 🖰 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4701 Willard Ave. 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 M Yes 2 No If Yes, Give WW Year or Dates. Baltimore, Maryland 21215-0036 3 Divorced 1 Yes 2 No Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Executive Officer Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Sturt Sadie Ableman .t. Page 1 and 2 shou...
-t of Health and Me
-v 7 is mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) Lisa Sturt 5156 Charmant Place, Atlanta, Georgia 30360 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. Date 6, Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 era Prvice Licensee 21. Si in ... 5 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Acute Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached I Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner? ンナスイナ、 Division of Vital Be 26. Place of Death (Check only one) 2 မ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatun 29d. Date signed (Month, Day, Year) 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) 20814 8600 Old Georgetown Rd. Bethesda, Maryland Natasha Haag, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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			For State Registrar	State of Maryland		rtment of I tificate of			giene 0 1 0	05616
7.7	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Las I a 4a. Facility Name (If not institution, give	n D. Stewart	:	4b. City. Town.	or Location of Dea	2. Date of Dea Month Februa	Day Year	
	Funeral Director	iei	2303 Peggy L 5. Social Security Number 6. So	ane	ast birthday) Yrs.	If Under 1 Year Months Days	Silver S	pring 8. Date of Birt	Mon: h, Year) 9. Birl	tgomery tholace (State or Foreign ountry) usylvania
	the Maryland 28a-f ehow	Director	10a. State 10b. County Maryland Montgo 10e. Street and Number		, Town or Loc		Silver Sp		10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or iteme 23a or 28e-f ehow many injury or other traumatic event, the Medical Examinat must be notified at ances.	by Funeral	2303 Peggy L 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ane 12. Was Decedent Ever in U.S Armed Forces? 1 Wyes 2 □ No 198 If Yes, Give Year or Dates: 199	8- 1		20910 Hispanic Origin? (Span, Mexican, Puer Specify:		14. Race - Ame Black, White Specify:	S.A. prican Indian,
Maryland 21215-0036	be filed within 72 hartal Hygiene. ad other then "netuevent, the Madical	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give k life. D	ent's Usual Occupind of work done O NOT use retire	during most of world) Loper 18. Mother's Na	me (First, Middle,	16b. Kind of Business Banka Maiden Surname)	Industry
	and 2 should be alth and Mental 7.7 is marked of traumatic even	To	Roger 19a. Informant's Name/Relationship (7 Tracy Gipson - M				and Number or R		Gipson r, City or Town, State, I Maryland	
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Fun ral Service Licen	Removal from State 20b. Ploce Web	ace of Disposemetery, crem. Sh Hill 22.	ition (Name of atory or other pla S Cemet Name and Addre	ery 03/	Date 03/2010 (nes-Rina	20c. Location - City or Granville, Ldi Funeral	Town, State
8760,	Physician /Medical Examiner with principle of the princip	licai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of the composition of the compshore	b	Penil ence of):	, 1			n Tumon	Approximate Interval Between Onset and Death 8 months
.O. Box 6	the death certifical y the attending phy ched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 □E	Ectopic pregnanc Other <i>(specify)</i>	у		23d. Date of del Month	ivery Day Year
Records, P	The law requires that the death centificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Ph	Part II. Other significant conditions co	intributing to death but not resu	lting in the und	derlying cause giv	ven in Part I.	23e. Did to 1 Y 24a. Was a	ın 24b. Were au	obably 4 _Unknown
		To Be Com	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3□ DOA Ott	26. Place of Deaner: 4 ☐ Nursing H	perfor 1 ☐ Yes ath (Check only or	med? death? 2 No 1 ☐ Yes	
Division of Vital	Attending I ir death. ector: After by the funer	Certification;	27. Manner of Death 1 Alvatural 2 Accident investigation 3 Suicide 4 Homicide Getermined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify)	28b. Time of Injury		ry at rk? Yes 2 ∏No		ow injury occurred treet and Number or Ru n, State)	ıral Route Number,
a	Hospita 4 hours Funeral ely fillec	edicai Ce	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death on and/or inve	occurred at the tilestigation, in my o	me, date and place opinion, death occu	a, and due to the curred at the time, c	ause(s) and manner as late and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	We	29b. Signature and title of certifier Patricia /c.	msko nay,	mg-	29c. Licens			ed. Date signed (Monti	
	Q X Sta Registr	te ar	30. Name and address of person who control of the state o	ompleted cause of death (Item	Rock	ville Pi	ke, 6-1	IC, Rock	ebruary Ville, III	20552

amend Please Type or Printing Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Stachowak 32 AM Vrace /Medical 4c. County of Death Examiner Jonns Hopkins Bayview Medical Center Baltimore Cuty 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth May15, 1923 9. Birthplace (State or Foreign **Funeral** 1□ M 21 F Months Days Hours Min England 218-26-8836 86 Director Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at Director 1 TyPYes 2 □ No Baltimore City Md. 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21224 U.S.A. 345 Elrino Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No "natural", or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify ð Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Hygiene Important; if item 27 is marked other tha any injury or other traumatic event, Ital. Clothing Shirt Presser 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Wallace Meadows Elsie May Parsons ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen White (Friend) 7204 Bridgewood Drive Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Holy Rosary Cem. 26,2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facilit Kaczorowski Funeral Home, PA Poter Dundalk Avenue Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final the scho to Physician disease or condition resulting in death) y cans /Medical Due to (or as a consequence of) Examiner yus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 🗷 No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed The certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Injury nours after death.

neral Director: At filled in by the fur investigation 1 □Yes 2 □No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 2-221/0 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0; a 31. Date filed (Month, Day, Year) . Registrar's Signature State FEB 26 2010 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year lucker Feb 0410 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>ontaomeru</u> Birthplace (State or Pereign Country) 6. Sex 1 D M 2 □ F If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Days Hours Min (Month, Day, Year) Director -36-26 Yrs Germanu Usual Residence of Decedent or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Bethe 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 20814 e 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 No Army "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) leacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked 19a. informant's N-me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura oute Number, City or Town, State, Zip Code) 20814 ciantle hase 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date VNK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13010, 21. Signature of a prvice License 22. Name and Address of Intility any 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death neart failure. List only one cause on each line Immediate Cause (Final disease r condition Ph sician/ 13 years diseas r condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year sate has been signed by the a page 2 should be detached it 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital Be 25. Was case referred to pedical 26. Place of Death (Check only one) examiner? Hospita Other: 1 Tyes 2 No |₽ 🖊 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowledge, death consend at the lime, date and plane, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number gives ? D43083 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Medical Center 9707 Rockville, M.D 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-01593 Kevin Terry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 05619 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 22, 2010 Kevin L. Terry Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 810 Lexwood Court **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director 219-08-3246 Foreign Country)MD Hours 25 Aug/12/1984 tk M 2 F Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits is 23a or 28a-f show MD Baltimore Dundalk 28a-f show 1 Yes 2 X No hours after death with the Maryland irector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 810 Leswood Court Ö 21222 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2X No 4 Divorced If Yes, Give Year 1 Yes 2 XNo specify: White ρ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) rmit. Pages I and 2 should be filed within 72 inpartment of Health and Mental Hygiene. pportant: If item 27 is marked other than ", jury or other traumatic event, the Medical E jury or other traumatic event, the Medical E item 27 is marked other than 'traumatic event, the Medical Baltimore, MD 21215-0036 Bricklayer Union 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bruce Terry Sharon Cumberland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Rutherford /brother 1100 Maple Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 2/27/10 Baltimore MD 4 Donation 5 Other Specify: Balto. ML 21. Signature of Funeral Service Licens 22. Name and Address of Facility Name and Address of Facility 300 MAce Ave. Balto Connelly Funeral Home of Essex 23a. Part I. Enter the disease, oldo failure. List only one cause of Physician plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and /Medical Oxycodone intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the bunal - transi The law requires that the death certificate be executed Physician/Medical X UNPENDED 23a,27,28a-f,per ME g901 3/8/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Year past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown signed by 1 be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pending Director: d in by the f 1 Yes 2 No Fd 2/22/10 unk 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be home or Town, State) 810 Lexwood Ct Dundalk, MD within 24 hours a To the Funeral L determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 23, 2010 30. Warne and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001 OCME 2006

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AMEND TIEM#5perFH, G901,3/4/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** HELEN THOANTON 11120 1 M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 52721334115086 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕏 F Months Days Hours Min. 430 32 0783 73 Director Ohio April 10,1935 Usual Residence of Decedent the Maryland 27 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Predict Exemitar man to profiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 🗶 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5719 Harpers Farm Road Apt. E 21044 Funeral U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural". or in-any injury or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disbursing Officer U.S. Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Rev Oneal Stover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Thornton (Husband) 5719 Harpers Farm Road Apt. E Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2-28-2010 Glen Burnie, Maryland 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service License Inc. Columbia, Maryland 21045 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYUCARDIAL INFALCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate 1 ☐Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After thi funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending nours after death.

neral Director: Af

y filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10053051 7310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HULLAL ATHA COUNTY CENBUAL WALTER 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 22 **Physician** 7:42 2010 PM February Tiefe1 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Waldorf 218 Westdale Drive WATUOIL

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Waturs Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F Yrs 59 May 5, Oklahoma 440-58-9575 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or Items 23a or 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 ☐ No or other traumatic event, the Medical Examiner must be notified Director Maryland Waldorf Charles 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20601 218 Westdale Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Missionary, Minister of Elementary/Secondary (0-12) College (1-4or 5+) Education, Administrator Religious Education 5Ť Pages 1 and 2 should be filed v nent of Health and Mental Hygie int: If Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Evelyn McClain Joseph Howard Wieneke ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau Waldorf, MD 20601 (Husband) 218 Westdale Dr., James Tiefel 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial _2 4 Ď Donation _2 ☐ Cremation 3 ☐ Removal from State 2/23/2010 Dayton, OH Wright State Univ. 5 ☐ Other (Specify) 22. Name and Address of Facility
Wright State University
3640 Colonel Glenn Hwy., 21. Signature of Funeral Service License Dayton, OH 45435 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) X **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760 Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2X No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2K No this certificate has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 Yes 2X) No 2 ER/Outpatient 3 ☐ DOA ٩ To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral . 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) 5 ☐ Pending investigation Iniury 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

·MA.

29c. License number

703

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's

30. Name and address of person who completed cause of death (Item 83a) (Type, Print)

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			For State	State of Mary	•	rtment of l		Mental Hy	00	10 05622
			Registrar 1. Decedent's Name (First, Middle, Last)		061	incate or	Death	2. Date of De		3. Time of Death
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April 100	Examin		4a. Facility Name (If not institution, give s	treet and number)			or Location of Dea	ith	4c. County	
		н	Blakehurst 5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	Towso		s. 8. Date of Bi	Balti	9. Birthplace (State or Foreign
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it of Noticel Examination in cellified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates:		Vas Decedent of it is it is the control of its investment of its i	Hispanic Origin? (pan, Mexican, Pue Specify:	rto Rican, etc.)	Specify	e - American Indian, k, White, etc. White
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ylar	ould be Menta arked aric e	10	Harry W. Wicks				Leonia			
Mar	d 2 shoth and the and 7 is m traum		19a. Informant's Name/Relationship (Type Charles Utermohle, I			•	tand Number or F e Ct. Mo			State, Zip Code) 21111
ē,	s 1 and of Heal		20a. Method of Disposition		Db. Place of Dispos cemetery, crem			Date		City or Town, State
<u>m</u>	Page nent o ant: If ury or		1 → Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		t. Johns			NK	Longgre	een, Maryland
Baltimore, Maryland	permit. Departi Imports any Inji		21. Signature of Funeral Service License	Min	22 10	Name and Addr 050 York	Rd. Tows	uck Tows on, Mary	on Funer Tand 212	Home, Inc.
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Sior	endin eath. or: Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(World, Day, 100	a) injury		Yes 2 □ No			
<u>X</u>	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		et, factory, office			(Street and Numb wn, State)	per or Rural Route Number,
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			Anawa M. to	Ren CRA	0	Ro	48402		2/25/	20/0
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:03 am February 24. 2010 Imbach orthea June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Edenton Assisted Living Frederick 8. Date of Birth (Month, Day,
June 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🗓 F Yrs. 1922 South Dakota 87 June 455-12-0317 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modical Examinar must be motified at 1 ☐ Yes 2 X No Frederick Directo Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number u.s.A. 21703 5849 Genesis Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: ģ Caucasian 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Home Economics Teacher 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Gertrude Wick Anton Hassinger ပ and i 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar 15525 Cattail Oaks. Glenwood. Maryland 21738 Health a Sara Cronk - Daughter Item 27 20b. Place of Disposition (Name of Baltumore Crematory) at Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State 02/26/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 d 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to wir as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page 2 performed? Yes 2 2 No 2 No 1 ☐ Yes 1 Yes of Vital or Attending Physician; the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ROS0603 2-24-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tawey Ne Frederick, Ud 21702 31. Date filed (Mou Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for Amend Iter	n 25 ^{State o}	of Mar ne, g	(y 60°, 027	epartment of 25/2010anb Certificate of	Health a Death	and M		giene Reg. No.20	10	05624
	Physicia	an.	1. Decedent's Name (First, Middle							2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		HAZEL ANNA WOOL				1			Februa	ry 2, 20	010	11:48 A ^M
	Examin	er	4a. Facility Name (If not institution			Contan	4b. City, Town,		of Death		4c. County	•	
weed .	Funeral	6	Greater Balt: 5. Social Security Number	6. Sex		. Center (In yrs. last birth	day) If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th	timor 9. Birth	place (State or Foreign
	Director		212~10~3407	1□M 2□F XX	94	Υ	rs. Months Days	Hours	Min.	Jan. 2	2,1916	Mar	y land
	and w		Usual Residence of Decedent 10a. State 10b. County		1.	10c. City, Town	or Location						10d. Inside City Limits
	Maryl -f sho	tor	Maryland Harford	d			Monkton						1 ∐ Yes 2 √∭ No
	h the	irec	10e. Street and Number				10f. Zip Code			I	10g. Citizen of	What Cou	ntry?
	23a c	Funeral Director	3803 Houcks Rd.					1111			USA		
	items	nne	11. Marital Status	12. Was Dec	orces?		Was Decedent of If Yes, specify Cub	Hispanic Ori ban, Mexicar	igin? (Spe n, Puerto I	cify Yes or No Rican, etc.))- 14. Rad Bla	ce - Ameri ck, White,	ican Indian, etc.
38	irs aft	by F	1 ☐ Never Married 2 ☐ Marri **X Widowed 4 ☐ Divorced	ed 1 ∐Yes If Yes, G Year or I	ive	'	1 □Yes 2 □ No	Specify:			Specif	^{fy:} Whi	ite
1215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Examinar must be notified at	Completed	15. Decedent (Specify only highes	s Education			Decedent's Usual Occu Give kind of work done		t of workir	20	16b. Kind of B	usiness/Ir	ndustry
2	ithin 7 ne. han "r	mple	Elementary/Secondary (0-12)	College (life. DO NOT use retire	ed)	(O) WOIKI	<i>i</i> g	Houseke	anin	g~Own Home
, D	be filed within 72 hours after death with the Marylan ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examinar mant to notified at		12 yrs. 17. Father's Name (First, Middle, I	· · · · · · · · · · · · · · · · · · ·	·		ousewife	18. Mothe	er's Name	(First, Middle	, Maiden Surnar		g-own none
Baltimore, Maryland 2	should be filed within and Mental Hygiene. marked other than " umatic event, he we	To Be	Albert Edward F							eth Wi		,	
ary		-	19a. Informant's Name/Relationsh	ip (Type. Print)		19b.	Mailing Address (Stree	t and Numbe	er or Rura	l Route Numb	er, City or Town	, State, Zi	p Code)
,≅	and 2 ealth a n 27 is		Gail P. Nuetzel	(Daught	er)		3 Houcks R			 -			
ore			20a. Method of Disposition Burial 2 ☐ Cremation	3 ☐ Removal from	State	20b. Place of I cemetery	Disposition (Name of crematory or other pla	ace)	D	ate	20c. Location		
		9	4 Donation 5 Dother (Sp	ecify)		Gardens	of Faith 22. Name and Addr		-5-20	1	Baltimo: Ol Belai	•	
Ra	permit. Departr Imports any Inji	6.5	21. Signature of Funeral Service L	la par l	2/		Lassahn F				ltimore,		
	-		23a. Part 1. Enter the disease, of	complications that	caused th	he death. Do no	t enter the mode of dy	ing, such as	cardiac o				Approximate Interval Between
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on	each line	. Homi	G						Onset and Death
,)	/Medical Examiner		resulting in death)	a. Due to	(or as-a	consequence of):						44
	Examiner	er	Sequentially list conditions,	b//	14000	CACLICAL consequence of	In home				1.1	1	More than
	uted I Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in interest cause)	Jue to	or as a	consequence of		_	Λ	1/2	/r		2 1/00 6
oʻ	exect an and rial-tra	Examin	that initiated events resulting in death) Last	cDue to	(or as a	consequence of);	1	V-70	ED BY MEDICA	I EXAMINEN		weers)
9/8	cate be executed oblysician and the burial-transit	dical		d				CERTIFICAT	M APPRO	VED BY MEDICA			
ຼິດ ×	leath certifica attending ph for use as th		IF FEMALE:	220 Huga a	teama at	f prognancy		-					
ROX	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death	3 ☐ Ectopic pregnan					ate of deliv onth	very Day Year
j	the d	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9 □ Unk		anie or death	J L Other (specify)						
ດ, J	uing Physician: The law requires that the drughter that can the cartificate has been signed by the funeral director, page 2 should be detached	by Pi	Part II. Other significant conditio	ns contributing to	leath but	not resulting in	he underlying cause gi	ven in Part !.		23e. Did	tobacco use con	tribute to t	the cause of death?
ğ	equire sen siç ould b		- Pleusal	Effusio	n					1 🗆	Yes 2 □ No	3□ Pro	bably 4 Unknown
Vital Records,	law r has be	Completed	Amroda	me to	DIC	ify				24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
a E	n: The icate har, r, page		Mulhiple	Olgan	fe	Puc				pend 1 □ Yes	2 No	death? 1 ∐Yes	2.2No
=	siciar s certii irecto	Be c	25. Was case referred to medical examiner? 1 2 Yes 2 TVo	Hospital:	Inpatient	2 C FD/O::t-	otions all post of			(Check only		h (0	w.)
0	g Phy er this eral d	n: To	27. Manner of Death	28a. Date	of Injury	28b. Ti	me of 28c. Inju	ıry at			idence 6 □Otl		iry)
Ö	endin ath. or: Aff	atio	1 Natural 5 Pending 2 Accident investig	ation	nth, Day,	rear) III)		Yes 2□	No				
DIVISION	or Atter de irrector n by ti	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned Zoe. Plac		y - At home, farr (Specify)	n, street, factory, office		2		Street and Numi wn, State)	ber or Rur	ral Route Number,
ם	pital o		29a. Certifier A Certifying	n Physician To th	o boot of	my knowledge	death occurred at the	time data ar	l capta be	and due to the	a cource(a) and m		stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	edical	(Check only 2 Medical I	xaminer: On the	basis of e	examination and	or investigation, in my	opinion, dea	ath occurr	ed at the time,	, date and place,	, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1 11	,		29c. Licen	se number			29d. Date signe	ed (Month,	, Day, Year)
	50		In Wellet	1 14.1).		16	7075)		2/3/	10	
	(p)		30. Name and address of person v	vho completed cau	se of dea	ath (Item 23a) (T	ype, Print) 1/8 4850			2	/	101	9,01
	Sta	te.	31. Date filed (Month Day, Year)	21/6/ 5/	Registrar	's Signature	1/2 4830	61:	5/1/6	1561	nmale,	190	0/204
	Registra		31. Date filed (Month, Day, Year)	010 2	FRA A	B. A	back						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ard Wiley, J	r.		artment of Health and Mental H	ygiene	
		Registrar	rtificate of Death	Reg. No.	3. Time of Death
Physicia cal Exami	3.10	1. Decedent's Name (First, Middle, Last)	Tr	Month Day Year February 3, 2010	2310 hrs
Licai Exaiiii		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
		2123 Callow Avenue Apt. 3	Baltimore	NIA	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	Foreign	place (State or
Director		165-46-4118 1×1 2 F 54	Yrs. Michael Bays	Jan. 3, 1956 Cour	ntry) Pa
, j		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location		10d. Inside City Limits
iow any		Md NA E	Baltimore.		1 Yes 2 No
ırylanı 8a-f st	cto	10e. Street and Number	10f. Zip Code	10g Citizen of What Count	ry?
ith the Maryland 23a or 28a-f show polified at once.	Dire	2123 Callow Ave Apt. 3	21217	USA	·
ms 23	uneral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- D Rican, etc.) 14. Race - America White, etc.	an Indian, Black,
r death or ite	Fun	1 Never Married 2 Married 1 Yes 2 No	1 Yes 2 No specify:	Specify: R	ca a K
rs afte ural".	Š	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business/In	dustry
2 hou "nate	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	Estate R	ecoveries
036 ithin 7. re. r than	omplete	12	Account Represent	tative Inc	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	O	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surname)	-
2121; wild be fill Mental H marked c event,	o Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State,	Zip Code) 900/0
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	Ĕ	Mc Marie F Wiley	17202 Ingleword	Ave. #108 Laulada	le.Ca.
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours at ment of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin		200. Modified of Dispersion	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or T	own/State
Pages ent of nt: If		1 Burial 2 Cremation 3 Removal from State 4 Penation 5 Other Specify:		4-2010 Balto.	Md.
Baltimore, permit. Pages I at Department of He Important: If its injury or other to		21. Signature of Funeral Service Lifensee	22. Name and Address of Facility JOSEPH L. RUSS	Funeral Home, P.	A
		23a Part I. Enjer the disease, or complications that caused the death	7-2-7-1 W. NOCTO	tuo. Balto Ma.	Approximate Interval
hysician هر Medical/		failure. List only one cause on each line.	clerotic Cardiovascular Disease		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hyperensive Amerosc Due to (or as a consequence)			
	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence	of):		
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	or <i>j.</i>		
sd sit	Examine	events resulting in death) Last Due to (or as a consequence	of):		
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical	UNPENOED X AMENOED 10e,201	per fh g900 2-26-10	vt	
60, ate be o hysicia e buria	Medi	IF FEMALE: 23c. If yes, outcome of pre		23d. Date of delivery	
687 ertifica ding p	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of c	2 Fetal death 3 Ectopic pregi	nancy Month D	ay Year
Box 68760, e death certificate buthe attending physical for use as the buthe	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
O. Be hat the de ed by the etached f		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to t	
, P.O. ires that the signed by	d by	Morbid Obesity		1 Yes 2 No 3 Prob	
ords, w requii	Set				topsy findings available ompletion of cause of
Recol The law cate has	Completed			1 Yes 2 ✓ No 1 Ye	s 2 No
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death Proceed and the certificate has been signed by the attending physici tely filled in by the funeral director, page 2 should be detached for use as the buri	Be C	25. Was case referred to medical examiner? Hospital: 4 logation 2	26.Place of Death (Chec		Scana
f Vid Physic er this ral dir	₽	1 Ves 2 No Hospital: 1 Inpatient 2 2.7. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA Oute 4 Nurs 28b. Time of Injury 28c. Injury at Work?	sing Home 5 Residence 6 ✔ Other 28d Describe how injury occurred	. 000110
on of anding Ph	ion:	1 Natural 5 Pending (Month, Day,Year)	1 Yes 2 No		
Division tal or Attendir us after death al Director: A	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ral Route Number, City
Div pital o ours afi	Certification:	4 Homicide determined (Specify)			
Di To the Hospital within 24 hours a To the Funeral I completely filled		one) 2 Medical Examiner: On the basis of examination	edge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as state d at the time, date and place, and due to th	ed. e cause(s)
To t To tl	Medical	and manner stated. 29b Signature and title of certifier	29c. License number	29d. Date signed (Mor	
	-	The letter led	O.C.M.E.	February 4, 2010)
O .		30 Name and address of person who completed cause of death (Ite	em 23a)		
U V		Victor Weedn MD JD Assistant Medical Exam	niner 111 Penn Street, Baltimore, M	D 21201	

FEBRUARY 22, 2010 1:30 p.m.

MARGARET WASKEY

		Please	Type or Pri					_		Legible.	
		For State Registrar	State of Ma	arylan		artment of I tificate of I	Health and N Death	vientai Hy	rgiene Reg. No. 1	2010	05626
Physicia Medi		1. Decedent's Name (First, Middle, Las Margaret H. Was						2. Date of De Month Februa:		,2010 Year	3. Time of Death 1:30P. M
Examir		4a. Facility Name (if not institution, give					r Location of Death			County of Death	
Funeral		Stella Maris 5. Social Security Number 6. Se	x 7. Age	e (In vrs. le	ast birthdav)	Ti If Under 1 Year	monium If Under 24 Hrs.	8. Date of Bi	rth	Baltir 9. Birth	nore place (State or Foreign
Director			□ M 2 🗓 F	78	ast birthday) Yrs.	Months Days	Hours Min.	May 8	,1931	Mary	yland
aryland a-f shov fied at	Funeral Director	10a. State 10b. County	1	10c. City	y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🙀 No
the M or 28	ρ	Md. Harfore 10e. Street and Number	<u>u</u>		<u> </u>	allston 10f. Zip Code	···		10g. Citiz	en of What Cou	**
h with ns 23a nust t	nera	1808 Plainvue Wa	· · · · · ·			210				USA	
Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X☐ If Yes, Give Year or Dates.	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White, pecify: Whit	etc.			
15-C	Completed	15. Decedent's Ed (Specify only highest gra	ducation de co <i>mpleted)</i>		(Give I	dent's Usual Occup kind of work done O NOT use retired)	during most of work	ing	16b. Kin	d of Business In	dustry
212 within giene. er than	Con	Elementary/Seconday (0-12)	College (1-4 or 5	+)		n. Assist			Medi	cal & Ma	anufacturing
filed tal Hyg	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	,		ırname)	
ryla buld be d Men marke matic	-	Joseph Linehan 19a. Informant's Name/Relationship (Ty	no Print\		T 401 14-11			yrn Fai		Ctata 7ia	Code
nd 2 sho ealth an m 27 is ner trau		Bruce A.Waskey	_	on			and Number or Run Farm Rd.				Md. 21084
Baltimore, Maryland permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.		20a. Method of Disposition 1 Description Description	Removal from State	C	lace of Dispo emetery, cren .ghview	sition (Name of natory or other plac 7	ce)	Date 5-2010		ation - City or Tost	
Baltil permit. F Departm Departm Importa any inju		21. Signature of Funeral Service Licens				2. Name and Addre	ss of Facility So	chimune	Fun	eral Ho	ne
	- 1	Bum a. U	Meller	1 41 41	D	9705 Be1				Md. 212	
Ph_sician/	2 4	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line a. NON SMA	LL CI	ELL LUI	NG CANCE		or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner			Due to (or as a	a consequ	ience otj:						
ted Transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a	a consequ	ence of):					7-1	
be executed sysician and he burial-transit		that initiated events resulting in death) Last	Due to (or as a	a consequ	ience of):						
Box 68760 death certificate be he attending physici led for use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23	3d. Date of deliv	rery
BOX he death y the atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	1			Ectopic pregnand Other (specify)	cy			Month	Day Year
ords, P.O. Be requires that the despensioned by the should be detached	by	Part II. Other significant conditions co	entributing to death b	ut not res	ulting in the u	inderlying cause gi	ven in Part I.				he cause of death?
ords	Completed							24a. Was		24b. Were auto	psy findings available
Reco	Som							auto perf 1 🗆 Yes	opsy ormed? 2 X No	prior to co death? 1 ☐ Yes	ompletion of cause of
of Vital Re Physician: The this certificate I	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:			26. P	lace of Death (Chec	k only one)			
n of Viding Phys	e: 10	27. Manner of Death	1 Inpatie	ry	ER/Outpatier 28b. Time of	nt 3 □ DOA 28c. înjur	y at UNursing Ho	ome 5 Res 28d. Describe			HOSPICE
eath. Pr: Afte	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		r, Year)	injury	M 1 🗆	k? Yes 2 🗆 No				
Division of Vital Records, tal or Attending Physician: The law requires re after death. al Director, After this certificate has been signed in by the funeral director, page 2 should be		4 Homicide determined	28e. Place of Injubulding, etc			eet, factory, office			Street and wn, State)	Number or Rura	l Route Number,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examinonly one) 3 X, Certifying Nurs	ner: On the basis of e	xamination	and/or invest	tigation, in my opini	on, death occurred a	t the time, date	and place, a	and due to the ca	use(s) and manner stated.
To the With Control		29b. Signature and title of contifier	INP			29c. Licens	e number 19792		29d. Date	signed (Month, 22/2 U/	
15		30. Name and address of person who c	ompleted cause of do			LLEY RD.	TIMONIU	M, MD 2	1093		
Sta Registr		31. Date filed (Month, Day, Year) FEB 26 2010	32. Registra	r'e Signat			THOMEO	2 2 2	<u> </u>		
DUMU 17 Pay 7/0	200		7-1	/-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Maryland	-				lental Hy	giene	Э		
			State Registrar			Cer	tificate o	of Deatl	h		Reg. No. 20 0 05627			627
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	naham						2. Date of De Month		ay Year	3. Time of	
	Medic	al	Francis E. Willi		CC A			. 19		Februar		9,2010	8;46A	М
	Examin	er	 Facility Name (if not institution, give str 	reet and numb	pe <i>r</i> j		4b. City, Tov	wn, or Location			40	c. County of Death		
	Formul		Gilchrist Center 5. Social Security Number 6. Sex		7. Age (In yrs. la	st hirthday)	If Under 1	Tows		8. Date of Birt	h	Ba1	place (State o	r Fornian
	Funeral Director			M 2 □ F	96	Yrs.		ays Hour		(Month, Da	y, Year)	3.1913 W	est Vi	rainis
			Usual Residence of Decedent						_ L	movembe	: I I	J. INIJ W	CSC VI.	LETITE
	land sho dat	tor	10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside Ci	-
	Mary 28a-1 otifie	Director	Md. Balto.			То	wson						1 🗆 Yes	2 🛚 No
	a or	<u>=</u>	10e. Street and Number				10f. Zip Co	ode			10g. C	itizen of What Cou	ntry?	
	h with	Funeral	1310 Dulaney Val					21286				USA		
	deat riten inerr			Armed Ford			las Decedent Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Spe ican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White,		
36	after Il", ol xami	d by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give		1	☐ Yes 2 🕅	No Spec	cify:				ite	
8	ours atura cal E	Completed	15. Decedent's Educ	Year or Date	es.	16a Deced	ent's Usual O	occupation			10h I	Visal of Decisions to	ali satar i	
15	an "n Medi	ם	(Specify only highest grade	completed)	1 == 5 -)	(Give k		lone durina m	nost of work	ing	100.1	Kind of Business Ir	laustry	
212	withir jiene. er tha the l		Elementary/Seconday (0-12) 6 th	College (1-4	+ or 5+)		Worke				Ste	el Indus	try	
P	filed all Hyg I oth		17. Father's Name (First, Middle, Last)					18. M	other's Nam	e (First, Middle,	Maiden	Surname)		
<u>/lai</u>	d be Menta arkec	욘	William Willingha	m				Zada	a l	Jnknown				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type	e, Print)		1						r Town, State, Zip	Code)	
	nd 2 ealth m 27		Maria Johnston		DTR.		<u> </u>		otting	gham, Mo	1. 2	21236		
Baltimore,	e 1 a If of H If ite or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from S	State 20b. Pl	lace of Dispos emetery, crem	sition (Name of atory or othe	of er place)		Date	20c. L	_ocation - City or T	own, State	
Ë	: Pag tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)			t Holy	Redee	emer	2-22-			lto. Md.		
3al	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	/1		5.00		Address of Fa				Funeral	Home	
	HU = 60	Ш	Durin Gill	128	2			air Rd				ld. 21236		
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that ca cause on eac	lused the death h line.	. Do not ente	r the mode of	f dying, such	as cardiac o	or respiratory an	rest,		Approximat Interval Bet	ween
2	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		molice		of T	Den	entia				Onset and I	Death
	Examiner		resulting in death)	Due to (o	r as a consequ	ence of):							0	
		ē	Sequentially list conditions, b.	True for to	ī as a colisedu	မောင်မှ တို								
. [red	mi	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	540 10 (0	. 45 4 55115544	0.100 0.7.								
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80 C	ate be executed physician and the burial-transit	dical Examiner	d											
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89	endin use	and a	Zob. Was decedent pregnant	c. If yes, outco	ome of pregnar	ncy	Ectopic pred	gnancy			- 1	23d. Date of deliv	very	
80)	death ne atto	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of d		Other (speci					Month	Day	/ear
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ita	ician certifi ector	To Be	25. Was case referred to medical examiner?	spital:				26. Place of D					(11)	. 1
Division of Vital Records, P.O. Box 687	Phys this ral dir	은	1 Yes 2 No	1 🗆 Ir	npatient 2 1	ER/Outpatient 28b. Time of		Other: 4 Injury at				6 X Other (Specif	n Gilch	,n'st
<u> </u>	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month	, Day, Year)	injury	М 200.	work?		28d. Describe h	iow inju	ry occurred		
sio	Atten r dea ctor:	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	of Injury - At hor	me, farm, stre				28f. Location (S	Street ar	nd Number or Rura	l Route Numb	er,
Vi	s after s after l Dire		4 Li nomicide determined	building	g, etc. (Specify)					City or Tou				-,
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending F completed filled in by the funeral director, page 2 should be detached for use as	Medical										ind manner as state		
h	he He in 24 he Fu	Med	(Check 2 Medical Examine only one) 3 Certifying Nurse											nner stated.
')	With To th		29b. Signature and title of certifier					cense numbe			29d. Da	ate signed (Month,	Day, Year)	
			yani Sit	CKN	10		RI	14919	4		2	124/1	0	
			30. Name and address of person who con						IA - =		- 11			
			Marian Grant, 31. Date filed (Month, Day, Year)					WSOA	1/1/	7 713	,04	-		
	Stat Registra		31. Date filed (Month, Day, Year) FEB 2.6 2010	32. He	gistrar's Signati	hast	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marlene Kathryn Winstead Month 2:22AM Februari 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Joe's Medical Center Baltimore DWSon Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day, 1 □ M 2**X** F Days 217-38-7574 69 **Director** Maryland 1940 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore White Hall 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20700 W. Liberty Road Funeral 21161 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Crownsville permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Hospital RNBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Phillip Dei Margaret Anna Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Winstead/ Husband 20700 W. Liberty Road, White Hall, MD 21161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funeral Chapel- Bel Air 1 Burial 2 X Cremation 3 Removal from State 03/01/10 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & 16924 York Road, Monkt Flant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line. ediate Cause (Final Metastatic Ph_sician/ Kenal Carcinoma ease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 X No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Acciden
Suicide Investigation 6 Could not be Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-25-10 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 160 lowson Khoo. M State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per court order \$982 12-5-16 vt.

COURT ORDER

Certificate of Death 05629 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Curhs wade 11:50 A M 2 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2□ F 218-28-8119 **819**1 76 W.Va Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Baltimore Randailstown MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Wedford Examiner must be an once. 211.33 USA 3530 Resource Drive Apt. 220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 25 Married African-American 1 □Yes 2 No Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eastern Stainless Steel Grinder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Jordan Sidney Wade ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Wade/ Nephew 6132 Ediynne Road, Baltimore, MD 21239 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans | 3-4-2010 Owings Mills, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licensee andone 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death 23a. Puril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer **Physician** Metastatic Lung disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No illed in by the fi investigation 2 Accident hours after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier > 1/5 RajapakseM:D 2/18/10 D0057 465 441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Av., s. 203, Baltimore, MD 21209. 2835 N.S. Rajapakse, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician February 25. 6:40A RICHARD DUNN WITLER 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Oak Crest Baltimore Parkville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 € M 2 □ F 219-16-4748 Jan 17,1923 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, Ite Madical Examinar must be notified at 1 □Yes 2 □No Director Maryland| Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No WW I I If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2**\(\)**No White <u></u> Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ite Me Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper <u>Newspaper</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be should be fi and Mental F Edward Nicholas Witler Agnes Sullivan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Witler Glinowiecki DTR 9654 Dixon Avenue Baltimore, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Green Mount Crematory Feb 26,2010 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the diseas or complic shock, or heart failure. List only on Approximate Interval Between Onset and Death ons hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate ha 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours within 24 hours To the Funeral 29a, Certifier La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD# RO6743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZIER 31. Date filed (Month, Day, Year)

State Registrar

FEB 2 6 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2 A Janet Marie Coru Woodrow 25,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City_Town, or Location of Death 4c. County of Death Examiner ICA ER 8. Date of Birth (Month, Day, 12, 19, 5. Social Security Number 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Days Months 12, Maryland 37 219-72-9832 1972 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No ns 23a or 28a-f sh must be notified Harford Edgewood Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21040 1842 John Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d other than "natu Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet L. Burchett George Woodrow ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 1842 John Dr. Edgewood, MD 21040 Kimberly Puckett / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2,26,2010 West Chester, PA R.A. Ferris & Co. 4 ☐ Donation 3 ☐ Other (Specify) 21. Signature duneral Suffice Line 22. Name and Address of Facility Tarring-Cargo Funeral Home, P. 333 S. Parke St, Aberdeen, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executattending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown certificate has been s rector, page 2 should l Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 100 1 Tyes 2 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ∐ Yes Certification: To this 27. May er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Vithin 24 hours arter co...

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar DHMH 17 Rev 1/2001 30 Name and address of person who completed

Month, Day, Year)

31. Date filed

MDG

CUND

cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year ZNAMIROWSKI **Physician** MILTON 16.15 ISADORE 21 2010 02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death xaminer Harford Bel Air Upper Chesapeake Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-08-1916 5. Social Security Number 6. S*e*x 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 X M 2 □ F MD213-10-8107 93 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Experience count by notified at 10a. State 1 ☐Yes 2/☐ No Director Harford Bel Air MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21014 USA 1105 Hendrix Ct Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2 🖾 No Specify Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, Ite Menta once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman/design Medical Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Znamirowski Mary Kendryna ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3006 Rolling Green Churchville, MD 21028 Marilyn A. Pahel Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 02-24-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa up of Fune Servi Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) PNEUMONIA ASPIRATION hysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): rtificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DEMENTIA 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? within 24 hours after death.

To the Funeral Director; After this certificate completely filled in by the funeral director, pag 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

MOODITA059 Division of Vital Records,

the 0

State Registrar

Medical

FRANZ 31. Date filed (Month, Day, Year)

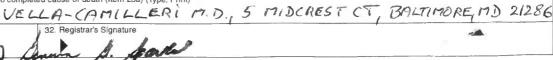
C.

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO21207

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Michael Ammann, Sr. Month 1:33 A M February 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth (Month, Day, Year) 11 M 2 I Months Days Hours Min. 220-42-3488 65 Yrs. Director ebruary 3, 1945 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Lothian Maryland 1 🗌 Yes 2 🔀 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20711 64 Edward Lane within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 6 δ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 X Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Heating and Air 11 Mechanic Conditioning Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil trment of Health and Mental rtant: If item 27 is marked or jury or other traumatic ew 2 Clyde Ellsworth Ammann Ada Veronica Bealle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Richard Matthew Ammann / Son 2763 Red Lion Place Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 20. February Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2010 Leonardtown, Maryland permit. Signature of Funeral Service Licer 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician puralori disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Exami the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No ate has been signed by the page 2 should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? Be funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 잍 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Privile 24 hours after death.

To the Funeral Director: After the Completed filled in by the funeral 15

Maryland 21215-0036

Baltimore.

11 11	- 10-47	
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurs of my knowledge, death occurs only one) Certifying Physician: To the best of my knowledge, death occurs only one) Certifying Nurse Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier Vaus ha Vani kar , MD	29c. License number DOU HJ89	29d. Date signed (<i>Month, Day, Year</i>) 0 2 16 10
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	s Rd. Clinton, M	120735

CK17378A State Registrar

Medical

32. Registrar's Signature

FEB 18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05634 Reg. No. Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Mary Lou Aorilio 12:15 PM February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 219-26-1967 72 8, Director Jan. 1938 Maryland Usual Residence of Decedent 10b. County Show 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Emminstratus be mailined any injury or other traumatic event, I'm Medical Emminstratus be mailined as Maryland Queen Anne's Queenstown Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 119 Pope Lane 21658 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White 2 Specify: 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Je filed with.

*I Hygiene.

* than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler 12 Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Emory O'Cain Frances Edmondson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Roy/daughter 119 Pope Lane Queenstown, Maryland 21658 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 2/13/2010 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Ser 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ime. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Rela Neumonia disease or condition resulting in death) as a consequence of) /Medical Examiner Sequentially list conditions Examiner If any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ed by the a 9 Unknown 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ After this certificate has been si funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ★ known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 340 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Apatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending 24 hours after death. Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State

30. Name and address

31. Date filed (Month, Day, Y

ed cause of deathy (Item 23a) (Type, Print)

2010

2001

Medral Pkin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 8901 3-10-10 yt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jamuuary Physician/ 34 20110 1053 а м Floyd Anderson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Washington Adventist Hospital Takoma Park 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** WV Country) 1X M 2 Months Days Hours Min. (Month, Day, Year, 235- 48-1385 Director 1932 Tune Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location the Maryland Director r 28a-f s notified MD Prince Georges Lanham Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ò must be r permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by by Funeral 20706 U.S.A. 7919 Johnson Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 1 Never Married 2X Married 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Laborer 10th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Turner Floyd Anderson Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobbie Barbara Ruffin Anderson 7919 Johnson Pl Lanham Md 20706 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Va Cem Feb 16, 2010 Cheltenham 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 22. Name and Address of Facility McLaughlin Funeral Home 20020 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 2019 Martin Luther King Jr Ave SE 2da. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DRONARY ARTERY DISEMJE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exam for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year 2 🗌 No 1 L Yes 2 L 9 L Unknown detached Division of Vital Records, P.O. burs after death.

eral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed DIABETES 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 300 2 ir D 40324 FEBRUARY 1,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSPRIE MD FACEP 7600 CARRELL AVENUE, TAKOMA PARK, MARYLAND 2 2010 31. Date filed (Mo 32. Registrar's Si State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of M	aryland		irtment of F tificate of D				giene Reg. No	2011	05636
	Physicia	n/	1. Decedent's Name)					2	. Date of Dea	ath Da	ay Year	3. Time of Death
	Medic	al	Jean Marie		atmat and number						ebruary	15,	2010	7:30 P _M
	Examin	er		k Hall Road				4b. City, Town, or Pa	rk Ha			40	c. County of Death St. M	n lary's
	Funeral		5. Social Security Nu	mber 6. Se		e (In yrs. las	t birthday)			er 24 Hrs. 8	. Date of Birt	h Veer	g, Birt	hplace (State or Foreign
	Director		036-24-8184 Usual Residence of E		_ W 2 KN F	72	Yrs.	WOTHIS Days	riouro	A	(Month, Day pril 14	, 19	37 Rhode	untry) E Island
	and show i at	or		10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
	Maryla 28a-f otifiec	rect	Maryland	St. Ma	ry's			Park	Hall					1 Yes 2 X No
	h the	al D	10e. Street and Num					10f. Zip Code				10g. C	itizen of What Co	untry?
	ath wit	Funeral Director	48144 Park	Hall Road	12. Was Decedent E	ver in LLS	13 14	20667 /as Decedent of Hi		rigin? (Specif	Ves or No.	1	USA 14. Race - Ame	
9	or ite	by F	1 Never Marrie	ed 2 🗓 Married	Armed Forces? 1 ☐ Yes 2 🛣		If	Yes, specify Cuba	n, Mexic	an, Puerto Ric	an, etc.)		Black, White	e, etc.
800	ırs aft ural", Il Exal		3 Widowed 4	☐ Divorced	If Yes, Give Year or Dates.		1	Yes 2 X No	Specif	iy:			Specify: Wh	ite
15-(72 hou	Completed	(Spec	15. Decedent's Ecify only highest gra			(Give k	ent's Usual Occupa ind of work done of		st of working	11	16b. k	Kind of Business	Industry
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br	filed wall Hyg	Be	17. Father's Name (Fi	irst, Middle, Last)	,				18. Mot	her's Name (F	irst, Middle,	Maiden	Surname)	-
yla	Ild be Ments larked	မ	Otto Radtk	e						Hele:	n Gendr	eau		
Nar	shou h and 7 is m rraum		19a. Informant's Nar	ne/Relationship (Ty	pe, Print)			g Address (Street a						Code)
e,	and 2 Healt tem 2		Robert Wil	liam Bain / osition	Husband	20b. Pla		Park Hall R	Road !	Park Dat	Hall, M		667 Location - City or	Town State
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🖸		Removal from State	cer	metery, crem	atory or other plac n Crematory		Februar 2010			xandria, V	
altii	mit. F partm portal y injui		21. Signature of Fun					Name and Addres	s of Faci	lity				
Ω	e a m e e	9	Priel	rael	Jardin	<u>~</u>		Mattingley P.O. Box 2	270	Leon	ardtown	<u>, MĎ</u>		
23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, oheart failure. List only one cause on each line.								Approximate Interval Between Onset and Death						
S.	Inysician Medical	ì	Immediate Cause (F disease or condition resulting in death)		a. CIEK	Has	15							Onset and Death
	Examiner		,		Due to (or as	z conseque	nce oi): EXVAL	- FAILE	int					
		iner	Sequentially list con it any leading to include to cause. Enter Underly	ditions,	b. Due to (or es.	a nonsirquii	nno ufic	PAILE	-					
	cuted ind transit	Examiner	Cause (Disease or iii that initiated events	njury	c. VIAB	_ /	- /	VD OB	ts//	7	_			
_	cate be executed physician and s the burial-transit	alE	resulting in death) La	ast	Due to (or as	a conseque	nce on.							
760	icate t phys sthe l	ledical		_	d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent p	regirant	23c. If yes, outcome 1 Live Birth	of pregnance	cy death 3	Ectopic pregnanc	*V			ļ	23d. Date of del	ivery
80 0	death the att	/sici	in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)					Month	Day Year
P.O.	at the od by t detack	, Ph	Part II. Other signific	eant conditions co	ntributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Pa	t I.	23e. Did to	bacco	use contribute to	the cause of death?
S, F	uires the signer of the signer	ed by									1 🗆 '	Yes 2	! □No 3 □ Pi	robably 4 🗆 Unknown
ord	w requ	Completed									24a. Was		24b. Were aut	topsy findings available completion of cause of
Rec	Physician: The law this certificate has ral director, page 2 and	Som										rmed?	death?	2 No
tal	cian: sertific ector,	Be	25. Was case referred examiner?	/ ti	Hospital:			26. Pla		eath (Check or	nly one)		<u> </u>	
Ž.	Physical direction	2	1 Yes 2 2 27. Man r of Death	No J	1 Inpati		R/Outpatien 8b. Time of	28c. Injury	4 ∪ i		5 2 Resid		6 Other (Special of the Control of t	ify)
o uc	nding ath. r: Afte ie fun∈	icat	1 Natural 2 Accident	5 ☐ Pending _ Investigation	(Month, Day	i, Year)	injury	work		_				
Division of Vital Records,	r Atte ter de irecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju		ne, farm, stre	et, factory, office		28	f. Location (S City or Tow		nd Number or Rui	ral Route Number,
۵	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Salo	one Certifier 1	Continue Dhus	inign. To the best of	more lan acciden	dae deede e	animad of the fire	dot	d =1=== == d =				tod
	e Hosi 24 hd e Fun	Medical	(Check 2	Medical Examin	ician: To the best of ner: On the basis of e e Practioner: To the	xamination a	and/or invest	gation, in my opinic	on, death	occurred at the	e time, date a	nd place	e, and due to the o	cause(s) and manner stated.
	Vithir To th Comp	2	29b. Signature and ti					29c. License	number				ate signed (Month	
	-0-		1/15	Helice	M.D.			D000				21	16/2010	
,	1 ene		30. Name and address	ss of person who c						PAMILY	2300	E	OHONS, 1	40 20188
	Stat	e	31. Date filed (Month)	Day, Year)	32. Registra			GEHAN R	1)	11/0	2100	JUC	UMUNS, 1	e oceio
	Registra			FEB 16			1. 1	arkel						

State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norma Joyce Basil February 2010 9:05 \mathbf{A}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Funeral Days (Month, Day, Year) 1/27/1933 North Carolina 1 M 2 X F Director 244-46**-**3696 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA Funeral 1974 Scotts Crossing Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en Bob Kepley Matti Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1974 Scotts Crossing Way #103, Annapolis, MD 21401 Robert A. Basil Jr. - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Hillcrest Memorial Gard. 2/10/2010 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Myclin 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final et and Reath Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Robably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Date of injury 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director. After t' Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide (Month, Day, Year) injury 5 Pendina Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February Robin Lynn Browning 2010 11:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 6036 Drum Point Road Deale Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Maryland Director 214-48-8565 Usual Residence of Decedent 28a-f show 10a. State 10b. County 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Anne Arundel 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 6036 Drum Point Road 20751 USA items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: Year or Dates white event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 payroll clerk MD State Comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 E11yson Browning. Sr. Virginia Lee Trott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Browning, brother 617 Phipps Road, Deale, MD 20751 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Our Lady of Sorrows 02-12-2010 West River, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ardiac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 1 Yes 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2: autopsy perform After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at w<u>ork</u>? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certif completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Wetifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Che within 2 To the I onl one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 250 av 31. Date filed (Month, Day,

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registra Amend#20b. PerFHPGC2-16-10cr Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EBRUARY Medical 4a. Facility Name (if not institution, give street, and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VAShing nmon If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday. Funeral 13€3M 2 □ F Months Davs Hours Min. 8/28/1984 Country) Mexico 25 Director none Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 A Yes 2 □ No NY Bronx Bronx 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1777 Monroe Avenue #1 10457 Mexico Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 🗚Yes 2 ☐ No Specify: Specify: Hispanic Mexican 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Busboy Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Petra Espiritu Inocensio Bautista 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave Bronx, New York Fredis Bautista/Sister Monroe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/14/2010 Guarrero, Mexico Igualita Cemeterio 22. Name and Address of Facility Marshall's Funeral Home Signature of Funeral Service Licensee Washington, DC 20011 4217 Ninth Street, NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner MO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No signed by the a d be detached f 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy death? nerformed' 2 🗌 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation within 24 hours after death

To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit of certifie M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CL 2

Registrar

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		For State Of Mar State Of Registrar		artment of F rtificate of L			Jiene leg. No 2010	05640
		1. Decedent's Name (First, Middle, Last)			•	2. Date of Dea Month	th	3. Time of Death
Physicia /Medic		PATRICIA ANN BLANCHF	ELD				Day Year RY 13 20	N.4
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	
		Chestertown Nursing & F	Rehab	Chester			Kent	
Funeral		4 🗆 11 0 🖼	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec 3	(Year) 9. Bi	rthplace (State or Foreign Country)
Director		218-26-8113	77 Yrs.			Dec 3	1932 Ma	ryland
and w		Usual Residence of Decedent 10a. State 10b. County	0c. City, Town or Lo	ocation				10d. Inside City Limits
f sho	ō	MD Kent	•					1 □Yes 2√€ No
the N	Director	10e. Street and Number	Worton	10f. Zip Code			log. Citizen of What C	Country?
with	Ē	11138 Old Worton Rd.		21678	.			ountry.
eath	Funeral	11. Marital Status 12. Was Decedent Ev	er in U.S. 13.				U.S.A. 14. Race - Am	nerican Indian.
fter d r iten	Fur	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		Was Decedent of H If Yes, specify Cuba		Rican, etc.)		
hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1⊡Yes 2 ½ No	Specify:		Specify: V	Vhite
2 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of Business	s/Industry
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be file tal H d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	, ,	,	
Men Men arke	မ	Arthur P. Bolton			Lilliar	n Mae I	Caylor	
2 short and list m		19a. Informant's Name/Relationship (Type. Print)	1				r, City or Town, State,	•
and lealth m 27 her t		Joyce Barzack (sister					1, DE. 19	
ges 1 If ite or ot		20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crei	matory or other plac	e)	Date	20c. Location - City o	
t. Pa tmer tant:		4 Dopatton 5 Other (Specify)					Earlevil	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inhortant: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at other.		21. Signature of Funeral Service Licensee	00510 Ĝ	2. Name and Addre Galena F 18 West	uneral H Cross S	Home of	Stephen ena, MD.	L Schaech
		23a. Part1. Enter the diagram, or complications that caused the shock, or hard failure. List only one cause on each line.	ne death. Do not en					Approximate Interval Between
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that the the the the the the the the the th	Phy	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Atter	ijį	2 Could not be	/ - At home, farm, str	reet, factory, office		28f. Location (S City or Tow	treet and Number or i	Rural Route Number,
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To the Hospital or Attending Physician: The law requires that the death cewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical (29a. Certifier (Check only one) 1 ertifying Physician: To the best of 2 dical Examiner: On the basis of eand manner state	examination and/or in					
orthe	Me	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date signed (Mo	nth, Day, Year)
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, ,		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type.		1,77			
ns		Frederick Delboy, M.D.			ill Rd.	Cheste	rtown, M	D. 21620
Sta		31. Date filed (Month, Day, Year) 32. Registrar					TI TI	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month O2 Physician/ 1255 pm 10 2010 Medical Facility Name (if not institution, give 4c. County of Death Examiner of War Baltimore werson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe 9. Birthplace (State or Foreign **Funeral** Davs Min. (Month, Day, Yea 9 / 29 / 1919 Country) MD 1 □ M 2 🗓 F 90 Months Hours Director 219-03-6986 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5811 South Hawthorne Ave. 21661 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No þ Maryland 21215-0036 1 Yes 2 XNo If Yes Give White_ Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Secretary Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Walter Harrison Hadaway, Jr. Nannie Newcomb permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Brown/Daughter 1100 Top Ridge Ct. Gambrills. MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel 2/19/2010 Rock Hall. Name and Address of Facility ellows, Helfenbein & Newnam Funeral Home 30 Speer Rd. Chestertown, MD 21620 Signature of Funeral Service Licer any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER sician and burial-transit Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day n signed by the a g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 9 Chronic renal 2 No 3 ☐ Probably 4 ☐ Unknown The law requires 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Lupeutension
25. Was case referred to medical 10erlipidema this certificate 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 Certificate: To ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 02.02.2010 27 Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending fell on bevelope 1 ☐ Yes 2 No UNKNOWN M Investigation 6 — Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Rouge Number 1)
5811 5. Hawthorne Ave. MD 2166 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined OSSISKA WING taculity Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02.10.2010 31. Date filed (Month, Da y, Year) State 16 FEB Registrar

DHMH 17 Rev 7/2009

			amend #5 Per	Type or Print FH G901 37	t in Black 11 /2 010 vland / De	Indelible In JH partment of	i k. Ensure Health and	All Copie	es Are vaiene	e Legible.				
		1	= State Amend 28b, 28 Registrar 30 per phy	Please Type or Print in Black Indelible Ink. Ensure All amend #5 Per rh G901 3/11/2010 JH Amend 28b,28f, State of Maryland / Department of Health and Mer te Amend 28b,28f, DOR,2/12/10 SBCertificate of Death							Reg. No. 2010 05642			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year 3. Time of Death				
	Medic	al	remael parned chester							4c. County of Death				
	Examin	er	Memorial Hospital at Easton Easton							Talbot Date of Birth 9. Birthplace (State or Foreign				
15	Funeral Director			1	63 Yrs	Months Days		in. (Month, May	Day Voor	A COU				
35	land show d at	ţō	10a. State 10b. County	1	0c. City, Town or	Location					10d. Inside City Limits			
F. >	Mary 28a-f	Director	MD. Dorch	nester	Can		4		1		1 12 Yes 2 □ No			
~~~	vith the 23a or st be	eral [	10e, Street and Number	u Roma	J	10f. Zip <b>O</b> ode	6/3		10g. C	Citizen of What Gou	ntry ?			
3	death v items ier mu	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ameri Black, White				
036	s after c ral", or Examir	ed by	1 ☐ Never Married 2 🗹 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🗷 N				Specify: 1	2 CK			
5-0	2 hour " <b>natu</b> edical	plet	15. Decedent's (Specify anly highest of	Education grade completed)	I (G	ecedent's Usual Occu ive kind of work done	during most of v	vorking	16b.	Kind of Business In	ndustry			
121	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed	Elementary/Seconday (0-12)  College (1-4 or 5+)  Pa 5 + 0 Y							2 hurc	h			
nd 2			17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maide								en Surname)			
Maryland 21215-0036			Lemuel Newbay Chester Sophia J							armon				
Ma			19a. Informant's Name/Relationship  Lavone	(lype, Print)	19b. N	ailing Address (Stree	t and Number or	1 1	ber, City o	1 41	yland 21613			
			20a. Method of Disposition  1 Burial 2 Cremation 3	Demoual from State	20b. Place of D	sposition (Name of prematory or other plants	7	Date	$\overline{}$	Location - City or 1	/			
Baltimore,			4 Donation 5 Other (Spe	cify)	Bethe	Cemete	ry 2/	13/2010	Ca	ubridg	e, MD.			
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	nsee Henre	2	22. Name and Addi	ref of Facility	Home	P.A.	ridge, M	0.21613			
			21. Signature of Funeral Service Licensee  22. Name and Address of Facility  HENRY Fune Ral Home, P. A.  23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
	Physician/		Immediate Cause (Final disease or condition resulting in death)  a. Complications following an Intraoperative  Due to or as a consequence of:  Bladder Perforation 2 days											
1	Medical Examiner		resulting in death)	Due to or as a c	onsequence of):			Bladde	r Pe	rtoration	2 days			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	onsequence of):									
	executed an and irial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):									
99	te be e) nysiciar ne buria	l = 1		■ d										
687(	ertifica ding ph	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy					23d. Date of deli	Mani			
Division of Vital Records, P.O. Box 68760	sician: The law requires that the death certificate be certificate has been signed by the attending physici rector, page 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		3 ☐ Ectopic pregna 5 ☐ Other (specify)	ncy		-	Month	Day Year			
0	at the o	2	9 Unknown								o use contribute to the cause of death?			
<u>s</u> , Р	uires th n signe ald be c										2 No 3 Probably 4 Unknown			
Sorc	aw req as bee 2 shou	Completed						24a. W	itopsy	prior to c	opsy findings available ompletion of cause of			
Re	The lacate h	te: To Be Com						1 🗆 Ye	erformed?	death?	2 No			
/ital	sician s certifi		25. Was case referred to medical examiner?  1 Yes 2 □ No	Hospital:	t 2 T ER/Outp		Place of Death (C		seidanca	6 Other (Speci				
of	ng Phy ter this neral c		27. Manner of Death	28a. Date of injury (Month, Day,	28b. Tim	e of 28c. Inju			e bow inju	ury occurred 5 u	xy ical			
ion	ttendii death. stor: Ai / the fu	Certificate:	1 Natural 2 Pending Investigation 6 Could not be determined See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Memorical Hospital At East for 219 South Fam. Street Easton, M)											
Divis	alor A safter al Direc	Medical Cert												
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
_	To th withir To th comp		29b. Signature and title of certifier	Dur Tye	Ment	29c. Licer			29d. D	Date signed (Month	, Day, Year)			
	(4)		30. Name and address of person wh	o completed cause of dea	th (Item 23a) (Ty	pe, Print) 2 (9 5	10/20	+. EAS	ion.	M 216	7,2010			
			8464 Avelou	Formi	load,	Easton,	Mask	nington	160(					
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	bouts	•							

10-01352

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Christopher Logan		bert, Jr - For State	State	of Maryland /		ent of He ate of De		d Ment		taa Na	201	0 0004
	R	egistrar	e (First, Middle,Las	)		ate of De	-		2. Date of Dea			3. Time of Death
Physician	-			, ogan Cober	t, Jr.				Month February	Day 14, 20	Year 10	0928 hrs
(				street and number)		4b. Cit	y, Town, or	Location of	Death		County of Death	
		12906 Cher	rywood Lane				wie			- 1	rince George	
Funeral Director	- 1	5. Social Security N 215-02-33		x 7. Age	e (In yrs. last bir 27		Inder 1 Yea onths Day		Min. 10/21		DD/YYYY) 9. Birt Foreig Cou	nplace (State or n Maryland untry)
		Usual Residence of Decedent									10d. Inside City Limits	
wany		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li									1 X Yes 2 No	
-f sho	ğ	MD		George's	Bowie	I 10f	Zip Code			10a. Citi:	zen of What Cour	ntry?
	2	10e. Street and Nu 12906 Ct	nerrywood	Lane		20	0715			US	Α	
ath with		11. Marital Status 1   ✓ Never Marri	ed 2 Married	12. Was Decedent Armed Forces?		13. Was Dec	edent of His ecify Cubar	spanic Orig n, Mexican,	in? ( Specify Yes or N Puerto Rican, etc.)	0-	White, etc.	can Indian, Black,
ter death		3 Widowed	4 Divorced	1 Yes 2 If Yes, Give Year	X No	1 Yes	2 X No	specify:			Specify: Whi	te
nurs af itural	핡	15. Decedent's Ed	ducation (Specify o	nly highest grade com	npleted) 16a.	Decedent's Us	ual Occupa	tion (Give k	(ind of work done	16b. I	Kind of Business/I	ndustry
72 ho	ompleted	Elementary/Seco	ondary (0-12)	College (1-4 or 5				. DO NOT	ase remour			
5-0036 led within 7 Hygiene. t other than	티	9			Ir	nstalla	tion_	10 Mathar	s Name (First, Middle	Maiden	HVAC Surname)	
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MD 2 shoulth and 1 is r				bert, Sr	-father	129	06 Che	errywo	ood Lane,		wie, MD	20715
	Ì	20a. Method of Dis				of Disposition		metery,	Date	20c.	Location - City or	Town, State
nor Pages ent of nt: If			Other Specify	Removal from Sta	ate	ity Mem		ās.	2/20/2010	Wa	ldorf, M	ID
Baltimore, permit. Pages I an Department of He. Important: If tie	ŀ		unetal Service Licer				and Addres					
W P P E		6512 NW Crain Hwy., Bowie, MD 20715										
Physician		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart defilure. List only one cause on each line.  Approximate Interval Between Onset and Death										
\ /Medical Examiner	-	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
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	miner	if any, leading to in cause. Enter Und	erlying Cause	Due to (or as a cons	equence of):							
sit of	۳   ي	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d,										
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'60, zate be		IF FEMALE:		23c. If yes, outcome		у				23	d. Date of deliver	
Sox 6876C leath certificate e attending phys	ä	23b. Was decedent past 12 month		1 Live birth Pregnant a	t time of death	2 Fetal de	eath 3 (Specify)	Ectopi	c pregnancy	100	Month	Day Year
Box e death c the atten	Physici	1 Yes 2	No 9 Unknow	, L		J Ouler	(Opeciny)					
o. B nat the d side by the etached	티	Part II. Other sign	nificant conditions	contributing to deat	th but not result	ing in the under	lying cause	given in Pa				the cause of death?
ords, P.C	g P	Coca	ine use					-			7-1-1	bably 4  Unknown  utopsy findings available
ords,	Completed									opsy	pnor to	completion of cause of
ecol he law ate has	Ĕ		-						1 <b>✓</b> Yes	formed?		es 2 No
of Vital Records, P. R. Physician: The law requires the Price of the this certificate has been signe neral director, page 2 should be d	BeC	25. Was case refe	erred to medical				26. Plac	1	(Check only one)			
Vita hysici this o		examiner? 1 ✔ Yes	2 No			Outpatient 3		Other ₄	Nursing Home 5		ence 6 🗹 Othe	r; Scene
n of ding Ph		27. Manner of Dea		28a. Date of Inj (Month, Day,	ury 28t Year)	o. Time of Injury		ury at Worl		e now in	ijury occurred	
sior trend death ctor: y the	atic	Pending Investigation Fd 2/14/10 Fd 8:11 am 1 Yes 2/2 No UTIK  Accident 2 Accident 2 Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City										
Division spital or Attendit hours after death. nneral Director: A	Certification:	3 Suicide	6X Could no determin	t be	ound at		ictory, omicc	ballaling, c	or Town	, State) ]	12906 Ch	errywood Ln
		4 Homicide    Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide										
To the Ho within 24 To the Fu complete!	Medical	one) 2	Medical Examin	er: On the basis of exa		r investigation,	in my opinio	on, death o	ccurred at the time, da			
To COT	Me	29b. Signature an	d title of certifier					nse number			Date signed (Me	
		10-n	0-	ım			0.0	.M.E. ———		_ Fe	bruary 15, 20	10
0112				completed cause of Assistant Med			enn Stree	et Baltim	ore, MD 21201			
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Regist	ate rar		FEB 22 2	010 Bens	wa B	par	4					
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Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month :42 AM 2010 4c. County of Death BALTIMORE 9. Birthplace (State or Foreign New York 10d. Inside City Limits 1 ☐ Yes 2 XNo 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc Specify: White 16b. Kind of Business/Industry Chemical Company 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21678 20c. Location - City or Town, State Worton, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 3010 MAZU LAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

FEB 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene 2010 State
Registrar Amend#20b, PerFHP002-19-10cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month 6:06 p M JUNG WOONG CHUNG FERRIIARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) 2/28/1943 9. Birthplace (State or Foreign Country) South Korea Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 1 🙀 M 2 🗆 F Hours Director 163-66-281<u>9</u> 66 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or Items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 ☐ No Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 USA 6811 Lamont Drive death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. , or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced 4 Divorced Year or Dates Asian 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) University Korean Elementary/Seconday (0-12) College (1-4 or 5+) Pastor Presbyterian Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Do yun Park Soon do Chung and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Maryland 20723 11044 Birchtree Lane Laurel, Soo Chung/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State  $2\frac{20}{13}$ , 2010 Olney, Maryland 4 Donation 5 Other (Specify) Norbeck Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 20011 Washington, DC 4217 Ninth Street, NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DISTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Examin and -transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed PULMONARY MYCOBACTERIUM FORTUITUM attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2-No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 1/2 Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Nur of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signat**r**ire ar

certifie

DANIEL CHERTOW

2010

31. Date filed (Month, Day, Year

FEB 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD-12817

FEBRUARY 3,2010

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Amend 7 per FD, DOR, 2/17/10, negistrat DB

1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death 3. Time of Death Feb Physician/ 219 rnestine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ta1507 Memorial aston 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🗷 F Months Hours Min. 62 **Director** Maryland items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Easton 1 Yes 2 No a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 216 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Janitoria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or out. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) arles Stow Maryland 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/2010 Voodlawn Mem. Park! 4 Donation 5 Other (Specify) Easton, Maryland Henry Fun eral Home, P.A. 510 Washington Street 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🗗 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? After this certificate I funeral director, page 2 🗌 No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 욘 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 1-1 Natural 2 🗌 No after death Accident Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print istrar's Signature State

Registrar

	sician edical miner	sertificate has been signed by the aftending physician and ector, page 2 should be detached for use as the burial-transi
	e IT	had hy the affending physician and
Department of Health and Mental Hygiene.	Me	
permit. Pages 1 and 2 should be filed within 72 hours after	Ph /I Ex	ician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygiene
Physicia		1. Decedent's Name (First, Middle, Last)  Thomas O. Davis, Sr.		2. Date of Death Month Day Year February 2, 2010 6:30 A M
/Medica Examine		4a. Facility Name (If not institution, give street and number) 13716 Lois Street	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington Co.
Funeral Director		5. Social Security Number $180-26-1457$ 6. Sex $1 \times 10^{-2}$ 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  Jan. 25, 1930  9. Birthplace (State or Foreign Country)  Pennsylvania
a-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  Maryland Washington Co. Hagerstown		10d. Inside City Limits 1 □ Yes 2√□ No
3a or 28g	al Director	10e. Street and Number 13716 Lois Street	10f. Zip Code 21742	10g. Citizen of What Country?
", or items 2	by Funeral	11. Marital Status  1 Never Married Married Married In Status  1 Never Married Married In Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married In Status  13. Was Decedent Ever in U.S. Armed Forces?  1 No If Yes, Give	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 No Specify:	
permit. Tages I and a Should be fined within 12 hours are to be an interior and particle be partitioned. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed t	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation of kind of work done during most of worki DO NOT use retired) COrder Cook	16b. Kind of Business/Industry
Mental Hygie arked other t atic event, th	To Be Co	17. Father's Name (First, Middle, Last) Charles H. Davis		(First, Middle, Maiden Surname)
alth and I				al Route Number, City or Town, State, Zip Code) - 8-F, Lebanon, PA 17046
ment of Heg ant: If item ury or othe		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Ematory or other place)	pate 20c. Location - City or Town, State lary 4, 2010 Reading, PA
Depart Import any Inj once.		21. Signature of Funeral Service Licensee  2 1  23a. Part 1. Enter the disease, or omplications that cause in a death. Do not en shock, or hard trailure. List only one cause on each line.	331 Eastern Blvd.	Interval Between
hysician /Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Due to or as a consequence of):  Sequentially list conditions	rt Failure : heart disca	Onset and Death  months
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).  c. Due to (or as a consequence of):		
aftending por use as	Physician/Mec		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
igne bed	ò	Part II. Other significant conditions contributing to death but not resulting in the unchronic obstructive ung disea	, , , , , , , , , , , , , , , , , , , ,	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
ate has	Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
sertifi	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatie	26. Place of Death	
fter this	ation: To	1		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
within 24 hour	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dear 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
To th	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Count	747 Northern Avenue.
State Registra	e	29b. Signature and title of certifier  Cynthia Kuther-Sands no  30. Name and address of person who completed cause of death (Item 23a) (Type, Cynthia Kuther-Sands no Hospice of  31. Date filed (Month, Day, Year)  S2. Registrar's Signature  FFR 26 2010	y wanty ton	" Hagerstown, Maryland

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
#23e Per Phy G900 2/26/2010 JH
State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Many and 7 Dec	Certificate of L			g. No. 7	0561.0
	Physicia	ın/	Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year 9, 2010	3. Time of Death
٠.	Medic	al	Robert Charles Evans  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	February	7 <b>9,</b> 2010 4c. Cou <i>n</i> ty of Deat	8:45p. M
1	, LAGITIII		18989 Bell Boy Lane	Valle	ey Lee		St. Ma	
	Funeral Director		5. Social Security Number $ 215-50-9489                                   $	Months Days	Hours Min.	8. Date of Birth (Month, Day, You 06/07/19	9. Bird 948	thplace (State or Foreign untry) Maryland
	and show	ro	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	Maryl 28a-f otifie	Director		ey Lee				1 ☐ Yes 2 🔀 No
	ith the 23a or st be n	ralD	10e. Street and Number	10f. Zip Code	0.0	10	g. Citizen of What Co	ountry?
	eath w tems 2 er mus	Funeral	18989         Bell         Boy         Lane           11. Marital Status         12. Was Decedent Ever in U.S.         1	2069 13. Was Decedent of Hill If Yes, specify Cuba		cify Yes or No-	U S A	rican Indian,
9800	ırs after d ural", or i	by	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, White Specify: Wh	e, etc. nite
15-(	72 hou n "nati fedica	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occup live kind of work done o e. DO NOT use retired)		ng 16	6b. Kind of Business	Industry
212	within giene. er thai		Elementary/Seconday (0-12) College (1-4 or 5+)	Owner/Ope	rator		Campgrou	ınd
pu	ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		_	e (First, Middle, Ma.		
IZ	ould by market market		Charles Francis Evans  19a. Informant's Name/Relationship (Type, Print)  19b. M	failing Address (Street a	Teresa	Irene		n Code)
, Σa	nd 2 she salth ar n 27 is er trau			0. Box 68,				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Rurial 2 V Cramation 3 Removal from State   cemetery, c	isposition (Name of crematory or other place eld-Echols	02/1	3/2010	Oc. Location - City or Charlotte	Ha11, MD
Balt	permit Depart Import any inj	150	21. Signature of Funeral Service Dicensee	22. Name and Addres 22955 Ho1				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	$\wedge$	65041	r respiratory arrest	,	Approximate Interval Between Onset and Death
\$	Ph_sician/ Medical	i	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Cance				Oriset and Death
-	Examiner		Sequentially list conditions, b.					
	sit sit	Examiner	if any, leading to immediate ocuse. Enter Underlying Cause (Disease or injury					
	aath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):					
90	te be e nysicia ne buri	Medical	d					
68760	ertifica ding ph		IF FEMALE: 23b. Was decedent proposit. 23c. If yes, outcome of pregnancy				T	
Box 6	ne death co / the atten ched for us	Physician/	in the past 12 months?	3	ey .		23d. Date of de Month	Day Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death of the Within 24 hours after death this certificate has been signed by the attendir completed filled in by the funeral director, page 2 should be detached for use	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause giv	ven in Part I.		cco use contribute to	the cause of death?
Secor	The law req tre has bee bage 2 sho	Completed				24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
ta	cian: 1 ertifica ector, p	Be	25. Was case referred to medical examiner?		ace of Death (Check			
ζ	Physi r this c eral dir	6:	27. Manner of Death 1 Inpatient 2 ER/Outpa		4 L Nursing Ho	me 5 🔀 Residence 28d. Describe how	ce 6 Other (Specinium occurred	eify)
on o	anding sath. rr: Afte	ficat	Natural 5 ☐ Pending (Month, Day, Year) injuited Accident Investigation	ry work			,,	
Divisi	tal or Atters after de al Directo	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	he Hospi in 24 hou he Funer pleted fill	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dear Medical Examiner: On the basis of examination and/or in Certifying Nurse Practioner: To the best of my knowledge.	vestigation, in my opinio	on, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
			29b. Signature and title of certifier	29c. License	) 5575	290	d. Date signed (Month	h, Day, Year)
١	Ochal		30. Name and address of person who completed cause of death (Item 23a) (Typ Jennifer Schmidt, D.O. 40900 M	lerchants L	Ane, Leon	ardtown,	MD 20650	
	Sta Registra	te ar	31. Date filed (Month, Day, Year) 6 2010 32. Registrar's Signature	bares			-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elliott Linda Louise Month Oa Physician/ Year М 7010 2308 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL WICOMICO CENTER SALISBURY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 222-36-2960 1 □ M 2 🕱 Months Days Hours Min 1010411950 Director 59 Delaware Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f Maryland Wicomico Parsonsburg 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 33719 Wango Road death with 21849 USA items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Yes Yes, Give 2 X No within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Specify: white Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) administrative assistant poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Singo White Doris Jean Gifford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32942 Kiwi Court West, Lewes, DE 19958 Grier White brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Salisbury Crematory 2 9 10 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Servic Licensee Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final and Death Pnysician/ disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year detached 9 Unknown g Unknown P.O. þ signed b Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes Completed 20 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) ٩ 1 Tyes 2 No 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation after death the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and tit

05

Name and address/of pers

in who completed cause of death (Item 23a) (Type, Print)

Legistrar's Signature

29c. License number

W507

MARROLL ST

29d. Date signed (Month, Day, Year) 8

SAUSBURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day February Physician/ 2010 Jans racy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COMICO DADION 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 1 **X** M 2 □ F Days Director or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No USSEX mar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19940 SA aware 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", 3 Divorced 4 Divorced 1985 Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sab ears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Vans Jennie earson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Čity or Town, State, Zip Code) 🛭 📗 Department of Health an Important: If item 27 is any injury or any 300 oman Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Dover 4 ☐ Donation 5 ☐ Other (Specify) Salisbury 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ HIV disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ESRD Sequentially list conditions, if any, sading to in readate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a nonsecrement of) CHF Exami tal or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical SEPTICE MIA Box 68760 as t the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 🗌 Yes ဂ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of rs after death.

n.e. al Director: After the filled in by the funera 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed within 24 To the Fur. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in this opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier M.D D57952

Registrar

DHMH 17 Rev 7/2009

State

504B , Salisbury, MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106 Milkord ST.

Das

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 902 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death Examiner 4c. County of Death Vicinio **Funeral** If Under 1 Year If Under 24 Hrs.

Months Days Hours Mrn. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 M 2 D F Months Country) 60 Director eb. Marylano Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No NICOMICO 5 bur 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral veclar 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No "natural", Completed 3 Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) reatment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Oliver rarrare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) antel atony Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location of ty or Town, State 1 Burial 2 Cremation 3 Removal from State 2/23/10 4 ☐ Donation 5 ☐ Other (Specify) thel Cemetery 21. Signature of Funeral Service Licensee 22. Name and Addres of Facility 510 Washington Henry Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequ sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 🔲 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has the funeral director, page 2 s performed death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 🗹 Natural 5  $\square$  Pending Accident 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: 76 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6.

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signat

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 February 7:30 a.mM Mary Catherine Guy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 44153 St. Andrews Church Road California St. Mary's Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Funeral, 1 □ M 2 🕅 F Months Days Hours Min. 07/297192 **Director** 217-30-0607 84 Usual Residence of Decedent sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗆 Yes 2 🛣 No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44153 St. Andrews Church Road 20619 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 X Widowed 4 □ Divorced Year or Dates White ed other than 'natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Men Important: If item 27 is marke any injury or other traumatic George Joseph Kraus, Sr. Queenie Victoria Gatton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Dean/Daughter 45020 Hewitt Road, Callaway, MD 20620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 02/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Michael's Cem Ridge, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to jor as a consequence oil. Exami Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 Yes Month Day Year 4 ☐ Pregnant g ☐ Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Jennifér Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year William Hamilton Gore 1945 ,2010 1-0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Salisburg Rehab Wur 5. Social Security Number | 6. Sex | 7 Wicomico Salisbi Sing . Sex 1 ☑ M 2 ☐ F 8 Date of Birth (Month Day, Year) OCT 26, 1920 Birthplace (State or Foreign Country) f Under 1 Year **Funeral** Days Months Hours 89 224-12-6394 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location is 23a or 28a-f show must be notified at tv⊟Yes 2 □ No Director Maryland Cambridge Dorchester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21613 403 Leonard Lane US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 and 2 shourd be filed within 72 hours after Health and Wental Hygiene, Y⊠Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 ☐Yes 2 ☑ No Specify þ Specify: White 3 □ Widowed 4 □ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ೭ <u>William M.H. Gore</u> <u>Virginia</u> Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Gene Theroux Nephew 7062 Brantley Drive Salisbury, Maryland 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dor. Memorial Park 2/13/10 Cambridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. the w) 700 Locust Street Cambridge, Maryland 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ode. disease or condition resulting in death) /Medical Due la (or as a conse , once of): **Examiner** 0 Seque maily list conuncing, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □ Yes 2 **⊡** No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 4 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miam H. Robins lisbury, MD M.D. rivia Ave. Da 200 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05654 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 11:30 AM Florence Elaine Houle February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center Mary's Leonardtown Social Security Number Age (In yrs. last birthday Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Hours (Month, Day, Year, 81 Yrs. Director 028-22-1432 January 4, Massachusetts Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Tes 2 X No Maryland St. Mary's Callaway 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 Point Lookout Road 20620 USA ural", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 X Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed Specify: White 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner / Operator Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Elizabeth V. Malone Houle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 206, Paul J. Houle Callaway, Maryland 20620 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t of = . 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State February 15, Department of Importants If any injury or Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2010 f Funeral Service License Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the ing, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not recultion in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician; The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 🚱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 4a. Was an 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🎏 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural injury 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

pml Gratis

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ess of person who complete Patrick James Jarboe

FER 1

MD

30. Name and add

24035 Three Notch Road, Hollywood, Maryland 20636

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Isabelle Evelyn Hossbach February 2010 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester Birthplace (State or Foreign Country)
 Delaware 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** ^{Year)} 1<u>921</u> (Month, Day, 1 M 2 F Days Hours Min 216-18-0190 89 Director Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🏝 No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Twin Point Cove Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secretary railroad 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry Crawford Fisher Mildred Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances H. Brannock daughter 3204 Ocean Gateway, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Johns Churchyard 2/19/10 Cambridge, MD rature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St. Cambridge. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ACIAN disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Artery Visease 1 Yes 2 A 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an OSTEDACTORITIES autopsy ☐ Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗡 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Tes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 200

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

Branble

Cambridge

21613

completed cause of death (Item 23a) (Type, Print)

100

gistrar's Signature

D.0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Registrar	of Maryland / Depar Cert	rtment of hificate of		d Mental H		eg. No. 201	0 0565
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Madeline K	atherine	Hickey			2. Date of Dear Month February 4	Day Year	3. Time of Death 1850 hrs
w /	4a. Facility Name (if not institution, give Southern Maryland Hospital	street and number)		b. City, Town, or Clinton	Location of Deat		4c. County of De	
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Yea Months Day			th(MM/DD/YYYY) 9.	
nnd show any nce.	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince Georg		Town or Location Washingt		-			10d. Inside City Limits  1 Yes 2 XX
the Maryland a or 28a-f sh tified at onc	10e. Street and Number	<u> </u>		10f. Zip Code		10	0g. Citizen of What C	ountry?
er death with , or items 23. r. must be no	1 Never Married 2 XX Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No	lf Y€		spanic Origin? ( S n, Mexican, Puerto specify:		White, etc	nerican Indian, Black, ∴ Vhite
5-0036 ed within 72 hours aft tygiene. the Medical Examine Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	college (1-4 or 5+) years	16a. Decedent during mo	's Usual Occupat	tion (Give kind of . DO NOT use ref		16b. Kind of Busines Medical	
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the Medica To Be Complé	17. Father's Name (First, Middle, Last)  John Edward M  19a. Informant's Name/Relationship (Typ	loran	19h Mailing		Lillian	Clear	Maiden Surname)  Y ber, City or Town, St	rate. Zin Code)
MD 2 12 shou th and N 27 is n umatic	George F. Hickey Jr.	·	N .	·				20744
Baltimore, Dermit, Pages I and Department of Heal Deportant. Il tien Injury or other tra	20a. Method of Disposition  1 XXBurial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Cre	ematory or oth	tion (Name of cer er place) n Cemetery		Date 6/2010	20c. Location - City  Clinton, N	,
Balt permit, Depart Import injury	21. Signat pe of Funeral Service License		61		ill Road O	xon Hill,		20745
Physician Medical Examiner	10d to 1 to 10 to		Do not enter th	e mode of dying,	such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that hitlated events resulting in death) Last	ue to (or as a consequence of):						
50, te be executed ysician and burial - transit	d. UNPENDED	AMENDED						
ox 6876 eath certifica eath certifica for use as the sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown	23c. If yes, outcome of pregnation Live birth Pregnant at time of deat Unknown	2 Feta	al death 3 [ er (Specify)	Ectopic pregna	ancy	23d. Date of deliv Month	ery Day Year
ords, P.O. Bow requires that the deast seen signed by the should be detached it	Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	derlying cause g	iven in Part I.	_		to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rafter death.  The death.  The first page 2 should be deated in by the funeral director, page 2 should be deated entification: To Be Completed by Perification: To Be Completed by Perification:						24a. Was a autops perfori	prior to med? death	
Vital Representation: The director, page	25. Was case referred to medical examiner?	spital: 1	R/Outpatient		of Death (Check Other Nursir		Residence 6 Ott	ner
rision of Vi r Attending Physi er death. ricctor: After this 1 by the funeral dir fication: To	1 V Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a, Date of Injury (Month Day Year)	26b. Time of In 1803 hrs	ury 28c. Injur	y at Work?	28d. Describe h	ow injury occurred uto fixed object	
Division o  Hospital or Attending 24 hours after death F Funeral Director: After tedy filled in by the fune all Certification:	3 Suicide 6 Could not be determined  4 Homicide Certifier Physician	28e. Place of Injury - At hom (Specify) Local Street		, factory, office bi	uilding, etc.	or Town, St		Rural Route Number, City Hills, MD
To the Howithin 24 h. To the Funcompletely	one) 2 ✓ Medical Examiner: O	<ul> <li>To the best of my knowledge in the basis of examination and and manner stated.</li> </ul>		on, in my opinion,	death occurred a		and place, and due to	the cause(s)
2	29b. Signature and title of certifier  Nowento The	2 Krill		29c. License O.C.N			February 7, 20	
R5 [	<ol> <li>Name and address of person who cor Margarita Korell MD. Assi</li> </ol>	npleted cause of death (Item 2 stant Medical Examine		nn Street, Ba	altimore, MD	21201		
State Registrar	31. Date filed (Month Pay, Year) FEB 12 2010	32. Registrar' Signatu	allel					

DHMH 17 Rev 1/2001 OCME 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month LON Hill Grizelle Μ. М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL SALISBURY WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Days Hours Min 0310211927 370-32-1829 Director 82 Yrs Sountry) Burma Usual Residence of Decedent show 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 605 N. Division St. 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 9 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other treasment. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) public schools media services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kenneth MacNair Grace Harkness 19a. Informant's Name/Relationship (Type, Print) Davina Hill daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 Cleveland Rd., Linthicum, MD 21090 20a, Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2|9|10 Salisbury Crematory Salisbury, MD of Funeral Service Licen 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23 . Par 1. Enter the disease, or complications that caused the lock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exam -tran resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 $\square$ No 2 Accident 3 Suicide 4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Box 68760 P.O. Records, Division of Vital Io une ...
within 24 hours after deau..

To the Funeral Director: After thi To the Hospital or Attending

State

Registra DHMH 17 Rev 7/2009

Medical

29a. Certifie (Check

only one 29b. Signature and tit

3

EB 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O.

Registrar's Signatu

100 E. CA/NI

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

3AUS by ey

29d. Date signed (Month, Day, Year)

2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of H			ne No. 2010	05658
o	Physicia		1. Decedent's Name (First, Middle, Last, ERIC		Jē	RPE		2. Date of Death Month February	Day 2010	3. Time of Death 19:35 M
-	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			The Johns Hopkins Ho			Baltimore	City If Under 24 Hrs.	8. Date of Birth	O Birth	place (State or Foreign
	Funeral Director		168-40-9252	X	Yrs.	Months Days	Hours Min.	(Month, Day, Yea May 2, 1	r) Cour	sburgh, Pa.
	ow t		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
:	a-f sh fied a	ctor	Maryland Prince G	eorges Gr	reenbe]	Lt				1 X Yes 2 □ No
:	or 28	Directo	10e. Street and Number			10f. Zip-Code			Citizen of What Cou	ntry?
,	sath w	eral	7814 Hanover Par	kway #201  12. Was Decedent Ever in U.S	3 113 1	20770	spanic Origin? (S		U.S.A.	can Indian.
	r item	Funeral	<ul><li>11. Marital Status</li><li>1 X Never Married 2 ☐ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 🕅 No	1	Was Decedent of His f Yes, specify Cubar		o Rican, etc.)	Black, White,	etc.
2-0036	ours a al", o Exami	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I∏Yes 2XNo	Specify:		Specify: Wh	
2-0	d within 72 hours after death with the Maryland gjene. Tr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation le completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor		. Kind of Business/I	ndustry
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	을 출 풀 눈	BeC	17. Father's Name (First, Middle, Last)	•	23002		18. Mother's Na	me (First, Middle, Mai	den Surname)	
/lan	lid b lentz rked ic e	To B	James Jerpe					McLain		
	2 S S		19a. Informant's Name/Relationship (T) Andrew Jerpe (Bro					ural Route Number, Ci 201 Greenb		
	1 and Health Sm 27 Sm 27 ther to		20a. Method of Disposition			esition (Name of	Trway #		Location - City or T	
Baltimore,			1 \ Burial 2 \ Cremation 3 \ \ 4 \ Donation 5 \ Other (Specify,	Removal from State	emetery, c <u>r</u> er	natory or other place Cemetery	Fob	.17,2010 ^{Pi}	*	
	permit. Page Department of Important: If any injury or once.		21. Sign au of Funeral Service Lious				s of Facility Re	ndon/Hale	Funeral H	ame
ñ	imp imp any any		Puchling 8)	end		_		. Lanham, 1		
Я			23a. Part 1. Enter the disease, or comp shock, or he y failure. List only o	ne cause on each line.				c or respiratory arrest,		Approximate Interval Between Onset and Death
) F	hysician / /Medical	4	mediate Cause Fin L disease or condition resulting in death)	a. Vancent	ble	eding				
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a e		iner	Sequentially list conditions, in any, reading to introduct cause. Enter Underlying			, .	,			
	cuted nd transit	Examiner	that initiated events	c. Hepatid		· 				
60,	ite be executed iysician and the burial-transit	dical E	resulting in death) Last	. Due to (or as a consequ	derice oi).					
	pricate t g physic as the l	0		d					1	
9 X	death certifica e attending ph ed for use as t	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of deli	
Box	the death the atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Other (specify)			Month	Day Year
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ds,	w requires that th been signed by t should be detac	d by						1 ☐ Yes	2 No 3 □ Pro	bably 4 🗌 Unknown
Records,	w requ	Completed						24a. Was an autopsy	24b. Were au	opsy findings available ompletion of cause of
Re	The law ate has l page 2	ome						performed	l?   death?	2  No
_		Be C	25. Was case referred to medical examiner?			Lau		ath (Check only one)		
<u>.</u>	Physic this cerral dire	2	1 ☐ Yes 2 No		ER/Outpatier		4 🗆 Nursing F	fome 5 ☐ Residence		ify)
Division of	ding Ph h. After thi tuneral	ion:	27. Manner of Death  1  Natural 5  Pending  2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	rat ? Yes 2 □ No	200. Describe flow i	rijury occurred	
VISI	deat deat tor: y the	fical	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Zoe. I lace of injury - At the				28f. Location (Stree City or Town, St	et and Number or Ru	ral Route Number,
ă	5 # # 5 =	Certification:	· ·	building, etc. (Specify						
	Hospital or 24 hours afte Funeral Dir letely filled in	edical	29a. Certifier 1	vsician: To the best of my knowiner: On the basis of examination	wledge, deatl tion and/or in	n occurred at the time vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the caus surred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hosp within 24 ho To the Fune completely fi	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d.	Date signed (Month	, Day, Year)
	ĕ <b>≯ ĕ</b> ŏ		1 Lp			R	ES 000	F	ebruak	24 72010
0	20		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)				
_	20			32. Registars Signal	ture . 4		600	North Wolfe	St, Baltimo	re, MD, 21287
	Sta	ite	31. Date filed (Mosth, Day, Year)	U. Heyland S Slota	alla.					

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Perstate of Maryland/Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Francis Calvin Knott 9:30 Рм February /Medical ^{4a.} Facility Name *(If not institution, giv*e street and number)
South River Rehabilitation Center 4b. City. Town, or Location of Death 4c. County of Death Examiner Edgewater Anne Arundel 5. 20rig Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□ F <del>266</del>-30-4619 77 Yrs. Director January 16, 1933 Maryland Usual Residence of Decedent 10a State 10b. County show 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any hjury or other traumatic event, it. Medical Examinatic event, it. Medical Examinatic profiled at Director 1 ∏Yes 2 X No Maryland Anne Arundel Lothian 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 493 Keith Road 20711 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White \$ Snecify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distribution Truck Driver 12 Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark Knott 2 Cora Quade 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39260 Wigeon Place Mechanicsville, MD 20659 Barbara J. Nelson / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State February 15, Leonardtown, Maryland Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service Licensee Serneth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovas cular diser **Physician** theroscienotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) P.O. the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Renal FOR LUDE 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown page 2 should coton 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Chronic certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) & RIME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 Decele

DHMH 17 Rev 1/2001

State Registrar

Road

20751

Church ton trans Signature

PEB 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16, Physician/ 2010 February 5:05 Joseph Anthony Kovalcik Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center Leonardtown St. Mary's Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Days Hours (Month, Day, Year) 02/05/1928 Director 82 Pennsylvania 209-20-9463 Usual Residence of Decedent show 10a. State 10b. County 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38051 Chaptico Road 20621 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Completed by 1 Yes : Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 Ind Mental Hygiene. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mill Company Salesman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kovalcik В. Krofchok Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Kovalcik/Son P.O. box 396, Chaptico, MD 20621 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 🔲 Burial 2 🔲 Cremation 3 🛣 Removal from State Rolling Green 02/20/2010 Lower AllenTownship,PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01206 22955 Hollywood Rd., Leonardtown, MD 20650 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mon rdiac or respiratory arrest. Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to it Exam requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical 68760 as t the attending partners and the state of the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Inknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s the Hospital or Attending Physician: The law autopsy certificate Yes 2 No 2 🗌 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 👺 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 3 ☐ Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 👣 e of certifier 29d. Date signed (Month, Day, Year) 6 Rme 30. Name and addre e of death (Item 23a) (Type, 24035 Three Notch Rd., Hollywood, MD 20636 <u>James</u> 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

An	mended	# :	26 per St. Mary' <b>Plea</b>	s,DLB ise Type or Pri	int in Blacl	k Ind	lelible Ink	. Ensi	ure A	II Copie	s Are	Lea	ible.		
			_ For		iaryland / D					-		_	1.0	0.5	
	_		1 - State Registrar  1. Decedent's Name (First, Middle.)	Loot	(	Certi	ficate of D	eath_			Reg. No	.2 U	IU		661
	Physicia		Satwant Kaur	, Last)						2. Date of De Month Februa		<b>½</b> . 2	oro	3. Time o 1:07	
Je 74.50	Medic Examin		4a. Facility Name (if not institution,	give street and number)	<u> </u>	4	b. City, Town, or	Location o	of Death	100100			of Death	1.07	
1			Southern Maryla				Clinton					ince	Geo		
	Funeral Director		217-59-7500	6. Sex 7. Ag	ge (In yrs. last birtho		If Under 1 Year Ionths Days	If Under: Hours		8. Date of Bi (Month, D April 6		54	g. Birthp Count Indi	lace (State only)	or Foreign
	and show at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town of	or Locati	ion				-		11	Od. Inside C	ity Limits
	Maryla 28a-f stified	Director	Maryland Charle	es	Waldor	f								1 🗌 Yes	2 No
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Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 4 ☐ Donation 5 ☐ Other (S)			cremate	on (Name of ory or other place -Echols		Fel	oate oruary 18. 201	ر ا		City or To	wn, State Hall,	MD
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			23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that cause	d the death. Do not	enter th	Nox 128, ne mode of dying	, such as o	cardiac c	r respiratory a	rrest,	206	22	Approximat	
M.	nysician. Medical		Immediate Cause (Final disease or condition resulting in death)	_a Acc	ITE M	400	andial	ynf	ari	tcon			4	Onset and	
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Division of Vital Records, P.O.	to the popular of Attending Priysicians. The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burit		4  Homicide determin	ned 28e. Place of Injuries building, etc					- 1	28f. Location ( City or Tov	wn, State)				er,
	ne nosp n 24 hou ne Funel pleted fil	Medical	(Check 2 \(\sumeq\) Medical Ex	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	examination and/or i	nvestigat	tion, in my opinion	i, death occ	curred at	the time, date a	and place,	and due	to the cau	se(s) and ma	nner stated.
	vithi To th	_	29b. Signature and title of certifier	MD			29c. License	number	180	0	29d. Date	e signed	(Month, D	ay, Year) 10	
al	,			who completed cause of d	leath (Item 23a) (Typ	pe, Print	MDO 1 Saer	is c	we	nue +	1100	Du	OSAA	1. M	1)
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State of Maryland / Department of Health and Mental Hygiene 05662 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 5, 2010 **Physician** Charles Louis Kendall 11:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min †☑ M 2□ F 577-46-1519 74 **Director** Sept. 5, 1935 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 24 No Prince George's Oxon Hill Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6914 Dudley Avenue 20745 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√√Yes 2 No 1954− 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1√√Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 K No Specify. ģ Specify: White 1956 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operation Agent Airlines 12 years 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Kendall Louis Ellen. Hen ley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth N. Kendall / Wife 7447 Little River Turnpike #101 Annandale, Virginia 22003 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 KkBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cemetery 02/17/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans habdomuoh Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Ye ar signed by the a Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐No Division of Vital 1 ∐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2∐No 11 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury
(Month, Day, Year)

28b. Time of 28c. Injury
Injury
Wo
1 

28e. Place of Injury
At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Fell at 1 Natural 5 Pending 2 Accident 3 Suicide investigation 1 ☐ Yes 2 ☑ No 24 hours after death.
Funeral Director: / filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6914 Dudley Ave., Oxon Hill, MD home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D223-3-0 2010 30. Name and add of person who completed cause of death (Item 23a) (Type, Print) MD 3001 Hospital Drive Cheverly, MD Matin. 20774 Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Febt 7, 2010 12:40 A M Joseph Michael Lehpamer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick Calvert Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July Day, Year 1926 1 Q M 2 D F Days Hours Min. Pennsylvania Director 83 204-12-8482 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2907 Oxon Park Street 20748 UnitedStates Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🕱 No Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) police officer law enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown Marcella unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6054 Hill Road St. Leonard, MD 20685 Karen Murphy- daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place b Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Alexandria Virginia 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRausch Funeral Home PA 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanad Chronic obstruction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Oneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Day Year P.O. I signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed Mild Congestive hunt failer with existen Frutanch 40% 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s performed? Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 2 X No ER/Outpatient 3 DOA 1 N Inpatient 2 -28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | 3 | only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43446 Roitan Fruha 2.7.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drw 15+1 12150 ROINTAN FARAHIFAR Annapolis Road Suite 312 Glenndale, MD 20769 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Februar Day Physician 5, 6010 /Medical 4a. Facility Name (If not institution, give street and number 4b City, Town, or Location of Death County of Death **Examiner** PrINCE Washing ton 4 Hrs. 8. Date of Birth Min. (Month, Day, If Under 1 Year | If Under 2 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Days 1 □ M 2 € F 77 134-26-6643 Dec. Director New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be motified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9112 Riverside Drive 20744 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 🎾 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher D.C. Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Thomas Francis Purce11 Alfarata Toomey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Gordon Liddy / Husband 9112 Riverside Drive Ft. Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any injury or once. St. Peter's Cemetery 2/12/2010 |Poughkeepsie, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Hone P.A. 21. Signature of Funeral Service Licensee MRI 6160 Oxon Hill Road Oxon Hill, Maryland 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **D**Kast (an (er **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Extra Unsurphing Cause (Disease or injury that initiated events resulting in death), act Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referre o medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 No Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0101236699 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
FEB 1 2 2010

Jotika P. Mangipudy, M.D.

22. Registrar's Signature

5226 Dawes Avenue Alexandria, Virginia 22311

# ■ Baltimore. Maryland 21215-0036

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	Exa	min
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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		State Registrar		Ce	rtificate of	Death	F	Reg. No. 2	05665
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/Medic	al .	Nancy Lee Miedzinski					Februar		
Examin	er	4a. Facility Name (If not institution, give street and me	ımber)			r Location of Deatl	1	4c. County of Dea	_
		26170 Jones Wharf Road  5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	HO.L.	1ywood If Under 24 Hrs.	8. Date of Birt	h 9. Bi	Mary 's rthplace (State or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 77 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Invitral Evandant to a Lifted at once.	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or	2 XNo iive		1 ☐ Yes 2 ☑ No		o riidan, etc.)	Specify: W	
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should nd Me mark imatik	ပ	19a. Informant's Name/Relationship (Type. Print)		19b. Mail	ing Address (Street			er, City or Town, State,	Zip Code)
nd 2 salth a 27 is r trau		James Wilson Miedzinski	/Husband	2617	70 Jones	Wharf Roa	ad Holl	ywood, MD	20636
item		20a. Method of Disposition	20h F	Place of Disn	osition (Name of matory or other pla Catholic	ice)	Date	20c. Location - City o	r Town, State
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permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	liner	2	2. Name and Addr Mattingley P.O. Box 2	ess of Facility r-Gardiner 1 70 Leonard	Funeral Ho Itown, MD	me, P.A. 20650	
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ding Physician: The law n. After this certificate has funeral director, page 2 s	Completed				_,,,,,,		auto		o completion of cause of
ician: The	Be	25. Was case referred to medical examiner?  Hospital:			O1	hor:	ath (Check only o		
P P 2	.To	27 Manner of Death 28a. Da	e of Injury	28b. Time	ent 3 1 DOA	4 Li Nursing		dence 6 Other (Since the control of	ресіту)
ding th. Afte	tion	1 ☑Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	onth, Day, Year)	Injury		orkí? ⊒Yes 2.⊒No			
I or Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Pla	ce of Injury - At h Iding, etc. (Speci	iome, farm, s	treet, factory, office			Street and Number or wn, State)	Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Medical C	29a. Certifier 1 Certifying Physician: To t (Check only one) 2 Medical Examiner: On the	he best of my kn basis of examin anner stated.	owledge, dea	ath occurred at the investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s) and manner , date and place, and d	as stated. lue to the cause(s)
To the comp	Me	29b. Signature and title of certifier  Attend	ing			0 0 5 5 6 8	72	29d. Date signed (Mo	onth, Day, Year)
1010		30. Name and address of person who completed ca	WO 23	130 M	e, Print)	it, lea	nard to v	un, Mo Z	0650
Sta Regist		31. Date filed (Month, Day, Year) 2010 32 FEB 09 2010	Registrar's Sign	ature	artes				
DHMH 17 Rev 1/2	2001			1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tay 4 Month February Physician/ 2010 9:15 a Charles Myers Morgan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Callaway Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🛣 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) **Director** 59 15-56-9476 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland St. Mary's Leonardtown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23830 Hollywood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 💢 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Carroll Morgan Ruby Pegg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Karla C. MacRae/Daughter Cartwright Road, Leonardtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 02/16/2010 Charlotte Hall, MD aneral Servi 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Walt N. Brinsfield 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or iinjury Day to for as a consequence of, Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the a 2 🗌 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to seath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IDDM cate has been sig 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate vulen To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to 25. W s case referred to medical Hospice House æ 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) Residence 6**XX**Other (Specify) Hospital 2 မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physic 29a. Certifier the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical E on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 10 eme

Registrar DHMH 17 Rev 7/2009

State

30. Name and add

James/C

Boyd

M.D.

41680 Miss Bessie Drive, Leonardtown,

MD

20650

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FEB Year 2.010 Addie Bell Mack 705 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital 8. Date of Birth
(Month, Day, Year) Leonardtown St. Mary's 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Mississippi 438-40-2523 Director 85 Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a 1 Tes 2XXNo Maryland St. Marv's Lexington Park 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21895 Pegg Road Unit #123 20653 United States items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) o. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", 3 Divorced Specify: Black Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 House Keeper House Keeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ed Mack Angeline Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21895 Pegg Road Unit 123 Lexington Park, MD. <u> Lizzie Mack Webster / Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If any injury or Department Brinsfield-Echols Cre Feb. 12, 2010 Charlotte Hall, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, PA. Kyle S. Simons M01206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL Physician/ HEMORILA GE disease or condition resulting in death) HOUSE Medical Examiner Due to (or as a consequence of): HYPERTENSION DAY Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Due to for sels consequence on Exami that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death 2 No g Unknown Ś cate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1XXNatural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

3 dl

Registrar
DHMH 17 Rev 7/2009

MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GiL

Registrar's Signatur

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31. Date filed (Month, Day,

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ASSOCIA TES

2-11-10

LEONARS TOWN MD 2850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Alberta Higgs Moye February 16, 2010 6:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Arunde1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 ⋤ F 577-12-9953 94 December 9,1915 Director Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2K No Directo Maryland Arunde1 Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2700 South Haven Rd. United States 21401 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No if Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates 1 ☐ Yes 2 XNo White Specify 3 XWidowed 4 ☐ Divorced 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ad Advisor Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Rothery Marian Foley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau James Higgs/Son 230 Autumn Chase Dr., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 18, 2010 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. 21. Sign vurs of Funeral Service Licenses PO Box 128, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) Yes 2. No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only one) and manner stated.

State Registrar

30. Name and address of person who completed cause

29b. Signature and title of certifier

31. Date filed (Month, Day,



of death (Item 23a) (Type, Print)

2100

29d. Date signed (Month, Day, Year)

arkung Amari

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Roy Wallace Morris February 11 2010 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Director <u>220-32-1104</u> 30 Aug. 23, 1929 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Examiner must be notified at 1 XYes 2 No Funeral Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2624 Rebecca Lane items 23a 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Yes. Give 1 ☐Yes 2 ☐Wo Specify. þ white Specify: 3 Widowed 4 Divorced Year or Dates: Completed event, the Medical 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) waterman seafood 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon L. Morris Sr. ၉ Mydra Meredith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vince W. Morris son β6967 Trout Terrace North, Fenwick Island, DE 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 2/18/10 Cambridge, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Se 515 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner arotid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 X Yes 2 No 3 Probably 4 Unknown Completed 2 bet 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 2 No 1 TYes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran P.O. Box 68760, Division of Vital Records, certificate Physician: this filled in by the funeral Hospital or Attending P 24 hours after death. Funeral Director: After t After

death with the Maryla

altimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 □Yes 2 □No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Une)		and mann
29b. Signatu	re and title of certifier	
<b>.</b>	and a	

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

Bramble St Cambri

completely

To the Hospital or within 24 hours a To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 13 2010 Erville Kenneth Moore 1:15 A. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester 900 Marshy Cove Unit 207 Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country)
 Maryland . Social Security Number 7. Age (In yrs. last birthday) Year) 1**X** M 2□ F Months Days Hours 218-20-8618 80 Feb. 1929 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits Dorchester Cambridge 1 XYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 900 Marshy Cove Unit 207 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 □Xes 2 □ No
If Yes, Give
Year or Dates: 1947–49 1 Never Married 2 Married 1 ☐Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) meat manager grocery 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Erville Moore Leota Davenport 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Moore wife 900 Marshy Cove Unit 207, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Crematory of Delmarva 2/15/10 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non small disease or condition resulting in death) Ce. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uncorping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

the Mindigal Examinant rust be notified at

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Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, It once.

Pages 1 ment of h

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death with the Marylan items 23a or 28a-f show

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Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran the attending p for use as t the page 2 s certificate director, this funeral After

P.O. Box 68760.

Division of Vital Records,

death. after death the filled in by 24 hours a completely within 2

Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed autopsy performed? Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 NaResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 408 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NICEWARNER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year Nelson February Louise 9:08 p.n. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u> Mary's Hospital</u> St. Mary's Leonardtown **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Mary land Months Days Hours Director 217-60-7370 Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If fiem 27 is and and feet than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23: edical Examiner must 21688 Ranger Road United States 20653 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jeremiah Aloysius Mason, Sr. Mary Florence Hebb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jones/Sister 44075 Louis Dale Road, California, MD 20b. Place of Disposition (Name of cemetery crematory or other place, Immaculate Heart of Mary Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/11/2010 | Lexington Park, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. M01206 22955 Hollywood Road, Leonardtown, MD Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardia Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 00 V5500 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed E42720 Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural

Accident 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 20^{Year} James Richard Norris, Sr. Αм 1:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea **Funeral** Country)
Maryland 1 **X** M 2 □ F Months Days 72 Director 217-34-0077 August 6. 1937 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director St. Mary's 1 Yes 2 X No Maryland Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20636 42891 St. John's Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importants if flem 27 is marked other than any injury or other trainments. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 James Jetson Norris Mary Louise Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42891 St. John's Road Mary Ellen Norris / Wife Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
St. John's Catholic Church
Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State February 22 4 ☐ Donation 5 ☐ Other (Specify) 2010 Hollywood, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockly or heart failure. List only one cause on each line. Approximate Interval Between Respiratory Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Multiorgan To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 25. Was case referred to nedical 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural work? 1 Yes 2 No 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

St. Mary" Hospital Point Looker Rd Lecnardtown, MD 20650

Registrar

DHMH 17 Rev 7/2009

State

10-01490	
Jonathan	Nolon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ionathan Nolon		l- For State Registrar	St	ate of Ma	ryland /		tment of ificate of		nd Mei	ntal Hy		Reg. No	201		05671
Physiciar Medical Examin	1/	1. Decedent's Name									2. Date of De Month	Day		3.	Time of Death
medical Examini		JONa 4a. Facility Name (if	athan		nd number)		1	4b. City, Town, o	or Location	n of Death	February		lc. County of D	eath	
		Bowie Health	Center					Bowie					Prince Geo	rge's	
Funeral		<ol><li>Social Security Nu</li></ol>	ımber	6. Sex			st birthday)	If Under 1 Ye	ear If Und	der 24Hrs.	1		M/DD/YYYY) 9 Fo	Birthporeign	lace (State or Maryland iv)
Director		220-39-31		1 XM 2	]F	16	Yrs		.,,		10/23	/19	93	Count	iry)
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death with the Maryland or items 23a or 28a-f sho must be notified at once.	֡֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֡֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֡֡֡֡֞֞֞֡֡֡֡	11215 Wes	stport					20720					USA		
ath wi ifems ?	Funeral	11. Marital Status  1 X Never Married	1 2 M		Decedent E ed Forces?	_		s Decedent of H es, specify Cuba				lo-	14. Race - A White, et		n Indian, 8lack,
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215-0036 be filed within 72 hours after mal Hygiene. "ked other than "natural", ent, the Medical Examiner	<u></u>	15. Decedent's Edu			t grade comp	oleted)		t's Usual Occup				16b.	Kind of Busine	_	
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21215-0036 Uld be filed within 7 Mental Hygiene. Marked other than ic event, the Medica	8	James E.	Nolon	ı					J	udith	A. Sp	enc	er		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Nam Judith A.			•			Address (Stre					-		ip Code)
mand 2 sho tealth and tem 27 is traumati		20a. Method of Dispo	osition	•			ace of Dispos	Westpo		T ,	Date Date		20720 Location - Cit		wn, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2			val from Stat	.~	ematory or oth	ion Ceme	n+0251	2/1	/2010		linton,	M	`
altin mit. P partme portan	ŀ	4 Donation 5 21. Signature of Fundament	Other Special Service	becify: Licensee		Ires	22. N	lame and Addre	ss of Facili	ity Bea	11 Fun	era	l Home	IVIL.	
M FSE		- //er	To	$\langle \rangle$			6!	512 NW (	Crain	Hwy.	, Bo	wie	, MD 2	2071	
Physician /Medical		23a. Part i. Enter the failure. List only		on each line.				ne mode of dying	g, such as	cardiac or	respiratory ar	rrest, sr	nock, or heart		Approximate Interval Between Onset and Death
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		Sequentially list cond	ditions,				y anoma	aly						$\perp$	
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Ox 6876 eath certificate attending phy for use as the l	2	3b. Was decedent property past 12 months?		ne 1 L	ive birth Pregnant at ti		2 Fe	tal death 3	Ectop	oic pregnar	псу		Month	Day	Year
Box 68760, a death certificate be the attending physici and for use as the buri	Physician/M	1 Yes 2 No	9 🗌 Unk	` 🖂 .	Jnknown	inie or dear	5 Oti	ner (Specify)							
2 2 2		Part II. Other signific	cant condit	ions contributi	ing to death	but not res	ulting in the u	nderlying cause	given in P	Part I.		_			cause of death?
Division of Vital Records, P.O. Isal or Attending Physician: The law requires that the start death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact															ly 4 Unknown
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Divis  Septial or A hours after of neeral Direct y filled in by	Certification:	3 Suicide		d not be	,	ıry - At hon	ne, farm, stree	et, factory, office	building, e	etc.	28f. Location or Town,		and Number o	r Rural	Route Number, City
Di lospital t hours a uneral I		4 Homicide 29a. Certifier 1 C		hysician: To the	ecify)	knowledge	death occur	red at the time	date and n	lace and	due to the cau	ise(s) a	and manner as	stated	
To the How within 24 h Worthin 24 h Completely	Medical			miner: On the ba											ause(s)
F 3 F 8	<b>E</b>	29b Signature and ti	tle of certifie		nor olatoa				nse numbe	er			Date signed		, Day, Year)
		family)	without	(m)				0.0	M.E.			Fe	bruary 19, 1	2010	
MA.		30. Name and addres			cause of de ant Medic			1 Penn Stre	et. Baltir	more. M	D 21201				
Stat	te		_Day, Year)	3	2. Røgistrar		9,		.,	, •••					
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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc, 10e per inf g901 3-15-10 ye. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dorothy Hendrickson Newsome Month **Physician** Newsome February 2010 1:45 endvicks р /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Kent Chester River Manor 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Ye. 3/14/1911 5. Social Security Number Funeral Hours Min. Months Days 1 □ M 2√□ F 98 219-34-3672 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show ral", or items 23a or 28a-f shov 1√ Yes 2 No Director MD Chestertown Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 87 Clipper Way Funeral 507 Cannon St. 21620 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify 2 3 ₩ Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.

7 is marked other than "natul traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Chaires George P. Hendrickson ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra 9265 American Legion Rd. Chestertown, MD 21620 Jack Newsome/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/13/2010 Pond Still Pond, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home Teck Of 130 Speer Rd. Chestertown, MD 21620 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary 304ears **Physician** Hrtery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) completely filled in by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by TV, Arthritis, Spinal 1 ☐ Yes 2.**17** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an Domentia autopsy performed 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1/1 Natural 5 ☐ Pending investigation 1 □Yes 24 hours after death. Funeral Director: A 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler

within 2

4

State Registrar

(Check only one)

29b. Signature and title of certifier

otteddavd MD 100 Brown

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Lostortown MD

29d. Date signed (Month, Day, Year)

2010

Am	end 10 r FH,2	e, /2	18 & 19b, <b>Plea</b> 2/10,	se Type or									
	HD, drw		For State Registrar	State o	t Marylan		rtificate			Mental Hy	/gierie Reg. No.	/ 11 1 1	05676
B	Physicia	- 4	1. Decedent's Name (First, Middle	e, Last)						2. Date of D Month	eath Day	20 Yea	3. Time of Death
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	Director		109-18-2216 Usual Residence of Decedent	1□ <b>★</b> 2□ F	86	Yrs.				01/23	/ 1924	, IVE	
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36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	12. Was Dec Armed For ried 1 ☐ Yes If Yes, Gi	edent Ever in U orces? 2 \ No ive X		Was Deceden If Yes, specify 1 ☐ Yes 2 ☐		anic Origin? ( Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	No-	14. Race - Ar Black, W Specify: V	
Maryland 21215-0036	vithin 72 hour ene. than "natural ie Medical Ex	Completed t	15. Deceder	nt's Education est grade completed)		16a. Dece (Give life. musi	dent's Usual C kind of work of DO NOT use i	occupation done during retired)	on ing most of w	orking	1	ind of Busine tertair	
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Mary	and 2 shou alth and N 27 is mai		19a. Informant's Name/Relations Shannon Rossi	ship (Type Print) - wife	74:								£ <i>ĕ</i> k ^c MD 20678
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 【3*Cremation 4 ☐ Donation 5 ☐ Other (			tropol:	osition (Name imatory or othe itan Fu	inera	1 Serv				or Town, State a Virginia
Balt	permit. Departi Importa any Inj		21. Signature of Funeral Service	e Licensee.			2. Name and / 405 Bro			Rausch F Rd. Port	unera Repu	al Home ublic,	MD 20676
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7	/Medical Examiner		resulting in death)		( r as a cons	quence of):							year
68760,	te be executed ysician and ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	o (or as a conse	typ	2052	lite	akun	. 8yn	elve	me	years
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician a completely illied in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live 4□Preţ 9□Unk		tal death 3 death 5	□Ectopic preç □ Oth <i>er (spec</i>	cify)			-	23d. Date of Month	Day Year
ds, F	uires tha signed I		Part II. Other significant condi	tions contributing to	death but not re	sulting in the	underlying cau	se given i	in Part I. Cruce		N.P		te to the cause of death? ] Probably 4 □Unknown
Division or Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed by			` /					24a. W - au pe 1 Ye	itopsy erform <i>e</i> d?	prior	
· Vita	ysician: s certific director,	To Be (	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:	]Inpatient 2[	☐ ER/Outpatio	ent 3 ☐ DOA	Other:		eath <i>(Check on</i> Home 5□R		6 □Other (	Specify)
sion or	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification: T	27. Manner of Death  1 Natural 5 □ Pend 2 □ Accident inves 3 □ Suicide 6 □ Coul	ling (Mo	e of Injury onth, Day Year) ce of injury - At	28b. Time Injury	М		at es 2 □ No		·	ury occurred	or Rural Route Number,
Divi	tal or At s after d al Direc ed in by	Certifi	4 ☐ Homicide deter	rmined 206. Flai	Iding, etc. (Spec	cify)				City or	Town, Sta	ite)	
	ne Hospi n 24 hou ne Funer oletely fill	Medical	29a. Certifier 1 Certify (Check only one)	ving Physician: To t al Examiner: On the and ma	he best of my ki basis of examinanner stated.	nowledge, de nation and/or	ath occurred a investigation, i	t the time in my opir	e, date and pl nion, death o	ace, and due to courred at the tire	me, date a	ind place, and	due to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certification	fier	$\subseteq$	K	7 29c.	License n	0617	83	29d. C	Date signed (A	Month, Day, Year)
)	RW 5		30. Name and address of perso	on who completed ca		em 23a) (Typ	e, Print)					/-/	
		tate trar	31. Date filed (Month, Day, Yea		Registrar's Sig		Same	w					
			1 1	U J. ZI ZUIL	LENER	- N	· parara						

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

423 Troopers Way

4a. Facility Name (If not institution, give street and number)

6. Sex

1 ☑ M 2 □ F

Richard

5. Social Security Number

12-28-1938 Director 175-30-6534 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Director Salisbury MD Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21804 423 Troopers Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after and the file of Health and Mental Hygiene. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No ģ 3 Widowed 4 Divorced "natural" Be Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, in Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychology Clinical Psychologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Siebert မ Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) /Personal Rep. 9746 North Shore Drive, Seaford, Delaware 19973 item 27 Joseph Gavlick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any injury or oth once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 2-9-2010 Signature Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Moor 705 E. Main Street, Salisbury, Maryland 21804 Part 1. Enter the disease, or corpolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASCUB **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Funcs after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform performed? 1 □Yes 2 ☑ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XIYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide n 24 hours after e Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title H50497 24 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21842 Salisbury hris Snyder 100 E Carroll St 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State **FEB 12** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Siebert

Months

7. Age (In yrs. last birthday)

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

Salisbury

Days

05677

0922

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Pennsylvania

Reg. No.

Day

Year

14. Race - American Indian, Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 1No

Year

Month

White

Specify:

2010

4c. County of Death

Wicomico

2. Date of Death

Date of Birth (Month, Day, Year)

Month

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ **FEBRUARY** 2010 7:42  $\mathbf{A}^{\mathsf{M}}$ EDWARD MICHAEL SULLIVAN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** QUEEN ANNE'S CENTREVILLE 170 SYMPHONY WAY 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Numbe **Funeral** Months Days 1 X M 2 🗆 F JANUARY 10.1936 PENNSYLVANIA 74 **Director** 187-28-1216 Usual Residence of Decedent show or 28a-f show be notified at 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No CENTREVILLE MARYLAND QUEEN ANNE'S 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I Funeral UNITED STATES 170 SYMPHONY WAY 21617 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed Year or Dates. 1957-1958 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARY OLEXA MICHAEL SULLIVAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains M. ELENA SULLIVAN/WIFE 170 SYMPHONY WAY, CENTREVILLE, MARYLAND 21617 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition FEBRUARY 9 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee Address of Facility HOME, HELFENBEIN AND NEWNAM FUNERAL HOME, FELLOWS FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P 408 S. LIBERTY ST, CENTREVILLE, MARYLAND 21617 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of e Approximate
Interval Between
Onset and Death
Manth caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final STAGE END CIRRHOSIS Physician LIVER DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner LIVER DISEASE (0 HOLI C Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and ned for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 2 🗆 No detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ ottolism 2 No 3 Probably 4 Unknown Completed eral Director: After this certificate has been si filled in by the funeral director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗆 Yes 2 🗆 No 26. Place of Death (Check only one) Be 25. Was case referred to meetical examiner? Other: 2 400 4 Nursing Home 5 K Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending Investigation 6 Could not be Accident after death Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature of certifie

State Registrar 30. Name and ag

ames

FFR-9

31. Date filed (Month, Day, Year)

MY

dress of person who completed cause of death (Item 23a) (Type, Print)

ber 1210

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of L 1. Decedent's Name (First, Middle, Last) Physician/ 7:00 p 2010 February Anthony Gray Scott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown Kent 115 N. Water Street 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign al Security Number 7. Age (In yrs. last birthday) If Under NY (nplac **Funeral** 1 🕅 M 2 🗆 F Days Hours Min. 1/11/1929 **Director** 067-28-0873 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Chestertown Kent MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21620 115 N. Water Street Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Research & Development Elementary/Seconday (0-12) College (1-4 or 5+) **Healthcare** 12 5+Chemist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rose Duly Robert Gray Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 N. Water Street, Chestertown, MD 21620 Jane Scott/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 2/15/10 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 . Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or se a nonesquance of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c, if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 🗌 No ate has been signed by the page 2 should be detached 1 ☐ Tes ∠ ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗌 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed certificate has 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred medical Be examiner? Other: 4 Nursing Home 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. May er of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗆 Yes 2 🗆 No M Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per phys. 6901 372/10 dk

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year M 2:50 February 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 23730 Owasso Rd. Chestertown Kent If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 🙀 (Month, Day, Year 5/30/196 Months Days Hours Min. Country) 48 Director 219-82-0493 MD Usual Residence of Decedent of Merial Hygiene. marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23730 Owasso Rd. 21620 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene Important: If item 27 is marked any injury or other to (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance YMCA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ollie Ervin Betty Leager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23730 Owasso Rd. Chestertown, MD 21620 David Schauber/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 2/13/2010 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 Speér 23a. Part 1. Enter the disease, or complication That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death shock, or heart failure. List only one ca Poorla Immediate Cause (Final Edeno coranoma of the Stones Physician Differents ated disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the t IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year 5 Other (specify) To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2X No Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Division 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Do M. D 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weshing

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) FEB 1 6 2010

32. Regietrar's Signature

21620

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	of Mary		-		lealth and <b>i</b>	Mental Hyg	jiene				
			State Registrar				ertificat	e of L	Death		eg. No. 🤈	010	05681		
	Dhyaiair		1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month	Day	Year	3. Time of Death		
	Physicia /Medic		Elizabeth V	/irginia	Thoma	S				Februar			12:24 P ^M		
	Examin		4a. Facility Name (If not institution	_			1		Location of Death			ly of Death Calve	n +		
			Calvert Memoria			um lant hirthm			Frederic If Under 24 Hrs.						
п	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F		yrs. last birtho Yrs	Months		Hours Min.	July 18	; Year)	lace (State or Foreign htry) rida			
	Director		264-16-9852 Usual Residence of Decedent	A	00					July 10	, 1923	F101	Liua		
	/land		10a. State 10b. County		10	c. City, Town o	r Location					1	0d. Inside City Limits		
	Mar a-f st	tor	Maryland Chari	Les		Cha	rlotte	Ha1	1				1 ☐ Yes 2 ☐ No		
	h the	Director	10e. Street and Number				10f. Zij	Code			l 0g. Citizen of	What Coun	ntry?		
	th wit		7675 Kent Drive	٤				206	22		Unite	d Sta	tes		
	r dea	Funeral	11. Marital Status	1 Armed	ecedent Ever Forces?	in U.S.	<ol> <li>Was Dece If Yes, spe</li> </ol>	dent of Hi cify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ace - Americ ack, White, (			
36	s afte	by F	1 ☐ Never Married 2 🛣 Marri 3 ☐ Widowed 4 ☐ Divorced	lt Yes, (			1 □Yes	2[ <b>X</b> No	Specify:		Spec	ify: W	hite		
<del>o</del>	hour tural	ed t	15. Decedent	Year or	Dates.	16a. De	ecedent's Usu	al Occup	ation		16b. Kind of I	Business/In	dustry		
75	in 72 n "na Andlic	Completed	(Specify only highes	t grade complete		— (G	live kind of wo	rk done d se retired	during most of wor f)	king			,		
212	d with giene r tha	E O	Elementary/Secondary (0-12) 12	College	(1-4or 5+)	Но	memake	r			At Hom	e			
פ	al Hyg othe vent,	Be C	17. Father's Name (First, Middle,	Last)	_				18. Mother's Nan	ne (First, Middle,	Maiden Surna	me)			
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∄	t. Partmen rtant;		4☐ Ponation 5 ☐ Other (S			Marylar			Cem.	22 201			am, MD		
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than. "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Macical Examiner must be notified at once.		21. Signature of Fundral Service Licenses MOO817  22. Name and Address of Facility Brinsfield-Echols F.H., P.A., PO Box 128, Charlotte Hall, MD 20622												
			23a, Par 1. Enter the disease, or	complications the			PO Box	. 128	, Charlo	tte Hall	., MD_2	0622	Approximate		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ELIZABETH MARIE TARQUINIO 2/11/201012:25 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **CAMBRIDGE DORCHESTER** DORCHESTER GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11/11/1919 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. 1 □ M 2 💢 F PENNSYLVANIA 90 163-14-2321 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23a or 28a-f show traumatic event, the Mudical Examiner roust be notified at 1 XYes 2 □ No Director **CAMBRIDGE** MARYLAND DORCHESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2407 BEECH ST. 21613 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify \$ Specify 3 ₩ Widowed 4 □ Divorced WHITE "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) RECEPTIONIST INTERIOR DESIGN 12 h and Mental Hygien 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental H sant: If item 27 Is marked oth Be SABATINO ANTONIO FRANCESCO PORCO MARIA ANTONETTA CIANGIARULO ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once. MARIA C. JOHNSON /DAUGHTER 2407 BEECH ST., CAMBRIDGE, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 02/22/2010 MCKEES ROCKS, PA ST. MARY'S CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Li 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on use h line. Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, example from editions cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician ned for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2010 3 Probably 4 ☐ Unknown 1 ☐ Yes should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 100 1 🗌 Yes 1 □Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ၉ 5 ☐ Residence 6 ☐ Other (Specify) nous after death.

nerai Director: After this
filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zugent

Registrar

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend 2 per phys, DOR, Registrar 2/24/10, LDB Reg. No. 2 0 1 0 Certificate of Death Decedent's Name 2. Date of Death Month 5 2005 2010 **Physician** February 3:04 AM M Esther Bradley Trice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖔 F Hours Months January 10, 1923 Maryland 87 Director 213-24-2699 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits se 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Salisbury Maryland Wicomico Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Booth Street IISA 21801 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates: Completed by Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leland Alvin Bradley Louise Gore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun Ellen Andrews/Daughter 4828 Northampton Drive, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2/6/2010 Crematory of Delmarva Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, 21. Signature of Funeral Se MD 21802 Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final RIMINARY DISEASE **Physician** CHRONIC disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 1 No Yes 2 1 No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 1 Yes 2 No 1 🔲 Inpatient 7 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne f Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) tural 5 Pending To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

0

Salisbury MD 21804

614 Easternshore Dr

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Mahesha Thimmarayappa M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year THOMPSON 12 . D 13 M AUDIZEY 01 2010 C 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Baltimore Future Care Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/01/1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2X F DC 577-56-9228 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No DC NONE Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20011 USA 58 Hamilton St. NW 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🏝 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appeals Officer IRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leola Johnson James Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 470 Lenox Ave. #3P New York, New York 10037 Wellington Thompson III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/12/2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brentwood, MD Lincoln Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nela tohe Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dichetes Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

Examiner bunial-transi attending physician the as detached ate has been signed by a page 2 should be detact

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, <u>the Medical Examiner must be notiffed at</u>

filed within Hygiene.

s 1 and 2 should be filed wi Health and Mental Hygien tem 27 Is marked other th

Maryland 21215-0036

Baltimore,

Pages

**Physician** 

/Medical

Examine funeral director,

Division or Vital Records, P.O. Box 68760

Thompson

Physician/Medical þ Completed Be Certification: To

To the Hospital of within 24 hours at To the Funeral D Medical State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifies

D 31464

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. HASHMIMD, SZI N. ENTAWST Suite 308 BALTIMORE MD 21261

31. Date filed (Month, Day, Year) FEB 12 2010

4 Homicide

(Check only one)

29a. Certifier

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death FEBRUARY 6. Physician/ EILEEN ELIZABETH TUCKER 2010 4:06 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **OUEEN ANNE'S** CORSICA HILLS NURSING HOME CENTREVILLE if Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Hours AUGUST 8 WASHINGTON, DC 81 1928 579-38-8890 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State Director Examiner must be notified 1X Yes 2 ☐ No MD QUEEN ANNE'S CENTREVILLE 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Numbe 23a Funeral 21617 USA 508 LITTLE KIDWELL AVENUE items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Nidowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT 11 OFFICE CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည CARLTON BEERS LILLIAN CARROLL le 1 and 2 should b t of Health and Mer If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 LITTLE KIDWELL AVENUE, CENTREVILLE, MD 21617 DONNA PHELPS/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot FEBRUARY 8 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MD CHESAPEAKE CREMATION 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HELFENBEIN & NEWNAM FUNERAL HOME, P.A. LIBERTY STREET, CENTREVILLE, MD 21617 Approximate Interval Between 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** PRINS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ardiomyspetty 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24 hours after death. Funeral Director: After this certificate has been si Funeral Director: After this certificate has been si eted filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

30. Name and address of person who completed cause of death

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death McElfish White 2010 Miriam February 6:45 p.mM. 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Country) Maryland 1 □ M 2 🛛 F Hours Min. 09/08/1925 217-20-2813 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland St. Mary's Mechanics ville 10e, Street and Number 10g. Citizen of What Country? 29795 Claire Circle 20659 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes Yes, Give 2X No 1 Yes 2XXNo Specify: 3 K Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+)

Waitress

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

M00052

PSI

Due to (or as a consequence of):

Due to (or as a consequence of)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Restaurant

20c. Location - City or Town, State

Mechanicsville, MD

GA 30043

Onset and Death

Angleberger

18. Mother's Name (First, Middle, Maiden Surname)

Μ.

02/13/2010

22955 Hollywood Rd., Leonardtown, MD 20650

22. Name and Address of Facility Brinsfield Funeral Home, P.A.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1705 Prospect Creek Dr., Lawrenceville,

Mary

Physician Medical Examiner for State Registrar

10a. State

Director

Funeral

Completed by

Be

မ

17. Father's Name (First, Middle, Last)

Jack McElfish/Son

4 Donation 5 Other (Specify)

19a. Informant's Name/Relationship (Type, Print)

1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State

Laward N. Brinsfield, JR.

Harry

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions,

disease or condition

resulting in death)

Cramer

Physician/

Medical

Examiner

**Funeral** 

Director

shov

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural",

of Health and Mental Hygiene. If item 27 is marked other than "natul or other traumatic event, the Medical

<del>-</del> 5 Department o Important: If any injury or

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the I	within 2	To the	complet	
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			•	۱.

lospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Exam Cause (Disease of I use as the burial-tran Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown cate has been signed by page 2 should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 4 hours after death. 1 Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, ed filled in by determined City or Town, State) Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) person who completed cause of death (Item 23a) (Type, Print) Name and addres Schmidt, 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650 D.O istrar's Signature Registrar **ORIGINAL** 

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1- For State of Maryland / De Registrar C	partment of Health an ertificate of Death	d Mental Hygi		05688			
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death			
	/Medic	al	John Thomas Willis			15, 2010	3:25 A M			
di di	Examin	er	4a. Facility Name (If not institution, give street and number)  Charlotte Hall Veterans Home	4b. City, Town, or Location of D  Charlotte Ha		4c. County of Death St. Mary's				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 I	Hrs. 8 Date of Birth	Birth 9. Birthplace (State or Foreign				
	Director		721-03-0003 1 <del>X</del> ^M ² □ F 87 Yrs.	Months Days Hours M	June 6,	$\stackrel{\scriptscriptstyle{Year}}{1922}$ Vir	intry) g <b>ini</b> a			
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits			
	Mary I-f sho fled a	tor	Maryland St. Mary's Calif	ornia			1 ☐ Yes 2 🛣 No			
	th the or 28a e noti	)irec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?			
	ath wi	ral	45137 Settlers Lane	20619		United States				
	items	Funeral Directo	11. Marital Status  12. Was Decedent Ever in U.S.  1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ No	<ol> <li>Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P</li> </ol>	? (Specify Yes or No- querto Rican, etc.)	14. Race - Amer Black, White				
936	urs aff	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Mes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh:	ite			
215-0036	flied within 72 hours after death with the Maryland Hygiene. Hygiene. than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of	f working 1	6b. Kind of Business/li	ndustry			
2	vithin ne. han "	JQ III	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)						
d 21	filed v Hygie sther t	ပ္ပို	17. Father's Name ( <i>First, Middle, Last</i> )	ef Petty Officer	Name (First, Middle, M	U.S. Navy				
Maryland		To Be	Wiley Jack Willis	Amy	, , ,	and or Carriagno,				
ar	2 shou and N Is mai	-	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number o	or Rural Route Number,	City or Town, State, Z	p Code)			
∑ ⊘`	and and marking markin			7 Settlers Lane,						
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev				entuary	0c. Location - City or T				
	nit. Paratme ortani Injury			1d-Echols Crem. 22. Name and Address of Facility B	16,2010   (	Charlotte F	MD D A			
ñ	Dep Imp any			PO Box 128, Char			, 1.A.,			
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as car	rdiac or respiratory arre	st,	Approximate Interval Between			
	Physician			R'S DISEAS			Onset and Death			
	/Medical Examiner		Due to (or as a consequence of):							
	1	je	Sequentially list conditions, if Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury							
	ocuted nd transit	Examiner	that initiated events							
/60,	ate be executed nysician and he burial-transit		resulting in death) Last  Due to (or as a consequence of):							
289	ficate physi s the t	edical	d							
XOR	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of deliv	/erv			
	e death	sicia	in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{No} \)  1 \( \text{No} \)	B □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year			
т Э	d by the	Phy	9 Li Unknown							
ďŠ,	requires that een signed b nould be deta		Part II. Other significant conditions contributing to death but not resulting in the ESSENTIAL HYPERTENSION		23e. Did toba	accouse contribute to s 2 ☑ No 3 □ Pro	the cause of death? bably 4 □Unknown			
ecora	w requ	etec		<u> </u>						
Y Y	The law te has b age 2 st	Completed by			— 24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of			
VItal	lan: rtifical stor, p	a)	25. Was case referred to medical	26. Place of	1  Yes 2 Death (Check only one	No 1 ☐ Yes	2□ No			
0	hysic this ce	To B	examiner?  1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpat	044	ng Home 5 ☐ Resider		ify)			
	IIng P		27. Manner of Death 11 ☐ Malural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how	w injury occurred				
ISION	death death ctor: y the	Certification:	2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	M 1 Yes 2 No	28f Location /Str	eet and Number or Rui	mi Flouto Number			
	at or / s after al Dire	State)	ar notite Walliber,							
	o the ithin 2 o the omplei	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Month				
)	FSFŐ		Decenter, MD	D0067789		2.15.2				
1.	,	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)						
<i>\( \bar{\bar{\bar{\bar{\bar{\bar{\bar{</i>			LEENA RAO KODALI, Charlotte	Hall, MD 20622						
	Sta Registr		31. Date filed (Month, Day, Year)  FEB 18 2010  Sensus A.	backer						
ULI	MH 17 Rev 1/20	5	. 25 /50 /50 /50	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Ralph Allen Williams, Jr. 2010 7:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's 8. Date of Birth (Month, Day, Year) August 27 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Washington, DC 577-48-1729 **Director** ,1935 er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 No ST. Mary's Maryland Charlotte Hall 10e. Street and Number 10g, Citizen of What Country? 29449 Charlotte Hall Rd. 20622 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Collection Manager Collection Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Williams Doris Licariane permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, 19a. Informant's Name/Relationship (Type, Print) 470 West Dares Beach Rd., Apt. 309, Prince MD 20678 Cornelia A. Williams/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 Burial 2 Tremation 3 Removal from State 4 Ponation 5 Other (Specify) Brinsfield-Echols Crem. 20, 2010 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Si nature M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tail are. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hemorrhagic Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami and I-transit Physician: The law requires that the death certificate be executed Vascular demenha that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 2 🛛 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier D67814 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29449 CHARLOTTE HALL RD CHARLOTTE 20622

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear **Physician** February Michael Arthur Wingo 10 2010 5:25 A /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4131B Maple Dam Road Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, June 29 Birthplace (State or Foreign Country) **Funeral** Maryland Months 1X M 2 □ F 67 1942 212-40-9406 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Dorchester Cambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 4131B Maple Dam Road 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Xres 2 □ No
If Yes, Give
Year or Dates: 1960–63 1 Never Married 2 Married 1∐Yes 2∐ANo Specify: white \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) dispatcher police 12 should be filed with and Mental Hygier 7 is marked other the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Adams Henry L. Wingo ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Heaith an Important: If item 27 is r any Injury or other traur Paula Wingo wife 4131B Maple Dam Road, Cambridge, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 2/17/10 Hurlock, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myeloceno /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical the use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day Month Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ☐Yes 2☐No signed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 ☐Yes 2 No 1 ☐ Yes 2 KNo To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ completely filled in by the funeral Certification: 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records.

State Registrar 29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1820 P ^M Feb 8 2010 Robert Isaac Wood /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth (Month, Day, July 26 Birthplace (State or Foreign
Country) Age (In vrs. last birthday) **Funeral** Hours 1 ☐ M 2 ☐ F Maryland 78 Director 216-30-4600 Usual Residence of Deced 10c City Town or Location 10d. Inside City Limits death with the Maryland 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 → No Prince Frederick Directo Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20678 5590 Hallowing Point Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white Baltimore, Maryland 21215-0036 52-54 þ 3. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction/ agriculture carpenter/ farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorena Stafford Isaac Vivian Wood ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellen Dwan Hardesty - daughter 5590 Hallowing Pt. Rd. Prince Frederick MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place)
Asbury Cemetery Feb 12 2010 Date 20c. Location - City or Town, State 20a. Method of Disposition Barstow Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Island Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or s a consequence of): Examiner METABOLEC Sequentially list conditions, Sequentially list condition to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1□ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral After (Month, Day Year) Injury 5 Pending investigation 1 / Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death. within 24 hours after death To the Funeral Director: completely filled in by the 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

arm 4+1
State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital Road Prince Frederick Maryland 20678

31. Date filed (Month, Day, Year)

32. Registrar's Signature

B. Lane

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05692 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 26 2010 10:35p.M Malik Waris Ali Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8649 Town and Country Blvd JB Ellicott City Howard 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** OI O1 1 🔀 M 2 🗆 F Months Days Hours Min. 129-70-0701 52 **Director** Pakistan Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Ellicott City MD Howard 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 8649 Town and Country Blvd JB 21043 Pakistan ritems death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ò 1 Never Married 2 X Married þ 1 Yes 2X No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 XNo Specify: "natural", Specify: 3 Divorced 4 Divorced Asian Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mex gones. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sureya Bibi Malik Mohammad Sharif 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8649 Town and Country Blvd JB, Ellicott City <u>Fazeelat Sarwar-Wife</u> 20c. Location - CMD To TSATE District Gujrat 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Pakistan 4 Donation 5 Other (Specify) Village, Karianwala 3/5/10 Punjab, 21. Signature of Funeral Service Licensee har war and Address West grette #300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ ung Can Cer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, oronary 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? pidemia 24a. Was an has autopsy perform certificate Diabetes Yes 2 N 1 ☐ Yes 2 🔀 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 🗖 Residence 6 C Other (Specify) 2 🔀 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 59027 03-01-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lavanya Varlagadda MD 2401 W Belvedere Ave, Baltimore MD 21215

Registrar

31. Date filed (Month, Day, Year)

MARO

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2 Physician/ 24 а м 2010 20 Elizabeth Adams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST CENTER BALTO TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 12-24 1 □ M 2 🂢 F N.C. Director 238-70-4286 68 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore na 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21214 4401 Mainfield Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 😾 Married 1 Yes 2XXNo If Yes, Give Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Westinghouse Wiring 2th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Everett William Earl Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 21214 4401 Manifield Avenue Balto, MD Leroy Adams-Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 3-2-2010 Randallstown, MD March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21202 Balto, 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final .⊁nysiciaπ disease or condition Medical resulting in death) Due to or as a consequence Examiner Sequentially flet conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 Months?

1 Yes 2 No Month Dav Pregnant at time of death signed by the a d be detached f 1 L Yes 2 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at wo<u>r</u>k? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signatur and title of certifie use of death (Item 23a) (Type, Print) 30. Name and address of person who completed cau

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/  $P^{M}$ February 8:23 2010 Gloria Louise Arno1d Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Nursing Center Towson If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours Country) 1 □ M 2 🙀 F Yrs Director 579-42-8804 Washington D. 0 84 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a -f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b County Director 1 Yes 2 No MD Baltimore Dunda1k 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 21222 USA 2031 Bear Ridge Rd. Apt. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No Specify: If Yes, Give Year or Dates Specify. White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Office Clerk Clerical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2031 Bear_Ridge Rd. Apt. 101 Dundalk, MD. Gregory Arnold (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date _1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 02/25/2010 Hilltop Service Corp. 4 Donation 5 Other (Specify) Towson, Maryland 22. Name and Address of Facility Duda- Ruck Funeral Home of Dundalk 21. Signature of Funeral Service Licensee 0 Dundalk, Maryland 21222 Inc. 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autop performe death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence ဍ 4 Nursing Home 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? (Month, Day, Year) Natural 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific cause of death (Item 23a) (Type, Print) 30. Name and add 6701 NCHARLES ST. SWITE 4105 BACTIMINE MD 21204

State Registrar

DANIEUE DOCEPNAN, M

31. Date filed (Month, Day, Year)

0 egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Day 4, Physician/ 6:30 A. M 2010 Bush Fannie Hazel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** May 8, 1918 Hours 1 □ M 2 💢 F Virginia 231-18-0806 Director 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Baltimore N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21212 U.S.A. 613 Cedarcroft Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker <u>6 years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Powers Russell Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Cedarcroft Road Baltimore, Maryland 21212 (daughter) Betty Carignano Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-27-10 Parkwood Cemetery Baltimore, Maryland Signature of Funeral Service Licenses Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 9. Joseph Fluras 6500 York Road Baltimore

23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on such lin Onset and Death Immediate Cause (Final Physician Wto disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine Due to for the a consequence of cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? Hospital or Attending Physician: The 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 Tes 2 No M Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

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State Registrar

Medical

31. Date filed (Month, Day, Year)

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29b. Signature and title of certifi

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4 Homicide

29a Certifier

(Check

only one

determined

30. Name and address of person who completed cause

ERNESTINE WRIGHT, M.D. 32. Registrar's Signature racke

of death (Item 23a) (Type, Print)

Examiner: On the basis of examination as

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2300 DULANEY VALLEY ROAD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

City or Town, State)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

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or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Baltinore 4a. Facility Name (if not institution, give Town, or Location of Death 4c. County of Death **Examiner** Homestead . Age (In yrs. last_birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day Country) Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notitied at once. 10c. City, Town or Location
Baltimore 10d. Inside City Limits Funeral Director 1 ¥Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Hlack Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 4 Ann Brown Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between 23a. Part 1. Enter the ease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter University Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed completed filled in by the funeral director, page 2 should be detached for use as the burial-transi this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Hospital 2 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nursa Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 333 halker 32. Registrar

Registrar

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23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22, 2010 210 Month **Physician** -ebruary ot/and /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner timore Year | If Under 24 Hrs. Date of Birth Month, Day, Year 5-7-191 9. Birthplace (State or Foreign Country) 5. Social Security Number 214-22-1504 7. Age (In yrs. last birthday, **Funeral** Months a **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Examinar must be rediffed at MD 1∰Yes 2 No altimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21201 USA thedra Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items any Injury or other traumatic event Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: lefen Brown 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 27 No þ Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) kind of work done during Elementary/Secondary (0-12) College (1-4or 5+) osmetolo 17. Father's Name (First, Middle, Last) er's Name (First, Middle, Maiden Surna Be Anna ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship MD 21085 305 foster Knoll Dr., Joppa, Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Licens Services 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5/5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Value (Underlying Value (Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-trar The law requires that the death certificate be exect Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.0. ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 X No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 1 M Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/22/10

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per. FH 6901 3/11/2010 at Health and Montal Hygiens

		1	State Registrar	State of Mi	aryland 1		rtificate of L		R	eg. No. 2	10,05698
	sicia edica	_	Decedent's Name (First, Middle,  EVELYN	Last) JANE	BAUBI	IIZ			2. Date of Deat Month February		3. Time of Death 9:20 a M
	mine		4a. Facility Name (If not institution,  DOVE HOUSE HOSE				4b. City, Town, or		h	4c. County o	
Fune	ral			i. Sex 7. Ag	e (In yrs. last I	oirthday)	Westmin	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)
Direc		-	212-18-4019	1□M 280F	91	Yrs.	Months Days	Hours Min.	Nov. 4		Maryland
land		-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
Mary a-f sh		į	MD Carr	:011		Fin	ksburg				1 □Yes 2 v No
ith the or 28			10e. Street and Number		,		10f. Zip Code		1	0g. Citizen of Wh	
eath w s 23a	1	Funeral Director	1512 Deer Pa	ark Road	From in 11 C	10.1		1048	Specific Vene or No.	U.S	- A -
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any initiar or other than "natural".		by Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☑ Widowed 4 ☐ Divorced	Armed Forces?			Was Decedent of H fYes, specify Cuba l □Yes 2½ No	spanic Origin? (S in, Mexican, Puerl	to Rican, etc.)		White, etc.  White
2-0050 72 hours aff		Completed	15. Decedent's (Specify only highest	Education grade completed)	16	(Give	dent's Usual Occup	durina most of wor	rkina	16b. Kind of Bus	
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filed v Hygic	9110		17. Father's Name (First, Middle, La	ast)		110	usewile	18. Mother's Nar	me (First, Middle, I		
Jental he	2	lo Be	John Sı	ıtch				Mary	Johanna	Fanton	
2 short and I small smal			19a. Informant's Name/Relationshi		1:	9b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	, City or Town, S	State, Zip Code)
1 and Health		-	Dennis R. Hitel	tell Nepher			Herdsman		Hampstead Date		1074 City or Town, State
ages ent of tt: If it	5		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	_	sition (Name of natory or other places  S Cemete	1 .	5/10		
Dermit. Pages Department of mportant: If it	9	ŀ	21. Signature of Funeral Service Li		500		2. Name and Addres				Mills, MD Road
	i a		Jan B	Dh	ne	EI	LINE FUNE	RAL HOME	Reister	stown, M	
		1	23a. P +t1. Enter the disease, or c	omplications that caused nly one cause on each li	d the death. D	o not ent	er the mode of dyin	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
Physici /Medic	_	1	disease or condition resulting in death)		ation	7	neumoi Demei	ma			Onset and Boats
Examir	-			1	a consequence	e of):	De ma	atra			
P +		ē	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	D.	a consequenc	e of).	ocme.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
ecute		Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
ficate be expression of the burial		<u>8</u>	,	Due to (or as	a consequenc	e 01).					
difficate g phys		edical		d							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and commission in by the funeral director man 2 should be detached for use as the burial-transit		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	Month  4 □ Pregnant at time of death 5 □ Other (specify)							
at the d by the		Phys.	9 Unknown	9 Unknown					oos Didas	h agas upa gentrii	bute to the cause of death?
ires the signed		2	Part II. Other significant condition	is contributing to death b	out not resulting	g in the ui	nderlying cause giv	en in Part I.			Bulle to the cause of death?  B □ Probably 4 □ Unknown
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The lay te has	2	Completed							autops perfor 1 □Yes	med? pr	rior to completion of cause of eath? □ Yes 2★ No
VILCII Ician: T certificat		e Re	25. Was case referred to medical examiner?					26. Place of De	ath (Check only or	•	LITES ZMALINO
Physic this or		0	1 Tes 2 No		ent 2 ER/			4 🗀 Nursing i			r (Specify) HOSPICO
Attending Physic death.  **Ector: After this by the funeral of the			27. Manner of Death  1 ★ Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da		o. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe n	ow injury occurre	a
Atten r deat ector:		Ea	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of In	jury - At home,	farm, str	eet, factory, office				r or Rural Route Number,
tal or rs after al Direction		Certification:	4   Hornicide	building, ei	tc. (Specify)				City or Tow	n, State)	
he Hospi in 24 hou he Funer	i i	Medical		Physician: To the best xaminer: On the basis of and manner st	of examination						
To t To t	5	Σ	29b. Signature and title of certifier	Lews	M	D	29c. Licens				(Month, Day, Year)  14 22, 2010  D 21061
7			30. Name and address of person w				Print) Road	103	alono.	maia MA	D 21061
7 7 7	Stat	e	K. Ambalava na 31. Date filed (Month, Day, Year)	20 50	rar's Signature			103	VI . E VI 101	אוועב יייי	
Reg	jistra		MAR 0 1	2010 Sun	m d.	1	artel				
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filton Jerome Bla	(e State (	of Maryland / Departm Certific		ntal Hygiene	. No. 2010	0569
Physician		<del></del>		2. Date of Death		3. Time of Death
Medical Examine	Milton Jerome E  4a. Facility Name (if not institution, give		4b. City, Town, or Location	Month February 7,	2010 4c. County of Deatl	0300 hrs
	633 Asquith Avenue, Apart	, , , , , , , , , , , , , , , , , , ,	Baltimore	(0) Boats	,	_
Funeral	Social Security Number     6. Sex	7. Age (In yrs. last bir				thplace (State or Foreign
Director	220-86-0645	M 2□F 43	Yrs. Months Days Hou	rs Min. Apr 20,	1966 Ma	ryland
any	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town	or Location			10d. Inside City Limits
	MD		timore			1 Yes 2 No
the Maryland a or 28a-f show	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Cou	ntry?
the part of the pa	633 S. Aisquith	Street	21202		USA	
or death with	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica		14. Race - Amer White, etc.	ican Indian, Black,
er dear		1 Yes 2 X No	1 Yes 2 Y No specia	'v'	Specify: 1 1	
nurs after		or Dates:	Decedent's Usual Occupation (Giv	e kind of work done	16b. Kind of Business/	
6 172 ho	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NC	Tuse retired) GTTK		ullr
5-0036 ed within 72 hour tygiene. other than "natu	10 17, Father's Name (First, Middle, Last)	0	18 Moth	er's Name (First, Middle, M	aiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than te event, the Medica	Milton Blake			rotht Lee He		
213 ould b d Meni d Meni d Meni d mari		pe, Print )	b. Mailing Address (Street and N	umber or Rural Route Numb	er, City or Town, State	e, Zip Code)
MD and 2 shoulth and all the and m 27 is summaria	Dorothy Johnson/		5217 Anthony Ave		e MD 212	
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	20a. Method of Disposition  1 Burial 2 Cremation 3		of Disposition (Name of cemetery, ory or other place)	Date	20c. Location - City or	Town, State
timent transity or of	4 Donation 5 X Other Specify: 21. Sign sure of Funeral Service Licens		22. Name and Address of Faci	lite.		
Bal Depart Impo		Wave, Mector	State Anatomy		Baltimore	Street
Physician	23a. Part List only one cause on each	cations that caused the death. Do n	Baltimore, MD of enter the mode of dying, such as	cardiac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/M di_l xaminer	Immediate Cause (Final disease a. h	lypertensive Atheroscleroti	c Cardiovascular Disease			Death
		ue to (or as a consequence of):				
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executed an and al - transit	d.					
		AMENDED				
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring a confineral Contribution. To Be Completed by Dhusician Modern	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	Fetal death 3 Ecto	pic pregnancy	23d. Date of deliver Month	y Day Year
ox 687 eath certific attending p	past 12 months?	4 Pregnant at time of death	Other (Specify)			
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w require		-	<del> </del>	24a. Was ar		utopsy findings available
ecol ne law te has gge 2 sl			· · · · · · · · · · · · · · · · · · ·	autops perform 1 Yes 2	ned? death?	
Vital Recc ysteian: The lav his certificate ha director, page 2			26 Place of Dear	h (Check only one)		
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ion of tending Pteath.  or: After the funeral		28a. Date of Injury (Month, Day,Year) 28b.	Time of Injury 28c. Injury at Wo	_	w injury occurred	
Division o spiral or Actending hours after death. neral Director: After filled in by the fune	2 Accident Pending Investigation	28e Place of Injury - At home f	arm, street, factory, office building,		reet and Number or Ru	ıral Route Number, City
Division or At ours after deal Direct filled in by	3 Suicide 6 Could not be determined	(Specify)	arm, surget, restory, emiss ballang,	or Town, Sta		and reduce real post, only
Division  To the Hospital or Attent within 24 hours after death To the Runeral Director: completely filled in by the		n: To the best of my knowledge, de	ath occurred at the time, date and	place, and due to the cause	(s) and manner as stat	ed.
To the How within 24 h To the Fur completely	one) 2 Medical Examiner:	On the basis of examination and/or and manner stated.			<u> </u>	
	29b. Signature and title of certifier	()	29c. License number	er	29d, Date signed (Mo	
	Mulabell		U.C.IVI.E.		February 22, 20	10
	36 Name and address of person who care Laron Locke MD. Assista		1 Penn Street, Baltimore, I	MD 21201		
Stat		32. Registrar's Signature				
Registra	TO MAK () I ZUIU	Course by 12				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	f Marylan		rtment of			lental Hy	giene		0.5	700
			Registrar  1. Decedent's Name (First, Middle, La	ect)		Cer	uncate or	Deam		2. Date of De	Reg. No.	2010	3. Time (	/ U U
	Physicia	an	, , ,	151)						Month Februa	Day	y 2010 4 2010	4:10	A M
	/Medic		Carol Brewster  4a. Facility Name (If not institution, given	o street and nur	nhar)	T	4b. City, Town,	or Location	of Doath	rebrua		County of Deatl		Α
	Examin	er	Brightwood Assis					rville				re		
-0	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th	Q Riet	hplace (State untry)	or Foreign
	Director		212-46-9348	1 □ M 2 🙀 F	92	Yrs.	Months Days	Hours	Min.	(Month, Da	19, <i>Year)</i> 191		_{untry)} .nsy1va	
	Di -		Usual Residence of Decedent											
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	8a-f	ectc	MD Baltimo	re		Luther								3 2 <u>A</u> _110
	with th	ä	10e. Street and Number	01 1 D	•		10f. Zip Code	21	.093		10g. Cit	tizen of What Co USA	untry?	
	sath s	by Funeral Director	504 Brightwood		dent Ever in U.	2 13 1	Vac Decedent of			acify Voc or No		14. Race - Ame	rican Indian	
^	fter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For	rces? 2 [XNo		Vas Decedent of Yes, specify Cu		n, Puerto	Rican, etc.)		Black, White		
Š	urs a		3 ☐ Widowed 4 🔀 Divorced	If Yes, Giv Year or Da	re ates:	1	□Yes 2∏No	Specify:				Specify: W	hite	
215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr				lent's Usual Occi		t of worki	na	16b. K	ind of Business/I	Industry	
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7	led w lygiel her ti	S	12	0			modeli		1 11	(First, Middle	8.4-1.4	magazin	es	
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Z	id 2 s lth ar 27 is trau		Gerry Brewster/s	, ,			Cuba Re					21030	ip code)	
e,	thea tem (		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of natory or other pl		D	Date	20c. Lo	ocation - City or	Town, State	
Ē	Page: ient o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Speci		State	етпесету, степ	latory or other pr	ace)						
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in fredical Ever-incr must be notified at once.		21. Signature of Funeral Service Lice	nsee ///	4/	22	. Name and Add	ress of Facili	ty	455 T.I	Do 3	ltimono	Ctmoot	
מ	e e E e e		Ronald S.	gane,	rector		ate Ana I <b>ltimore</b>	-			ра.	ltimore	Street	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that cone cause on e	aused the death	. Do not ente	er the mode of d	/ing, such as	cardiac o	or respiratory a	rrest,	İ	Approxima Interval Be	etween
4.	Physician		Immediate Cause (Final disease or condition	. <	strok	e							Onset and	Death
	/Medical Examiner		resulting in death)	Due to (	or as a consequ	uence of):	05	, , ,					3	
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	erice oi).										
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	e dea the at red fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)					Month	Day	Year
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ě	has ge 2 s	Completed by	Cos or arry	- RES M	1) ISEA	7×				24a. Was auto	psy	doath?	completion of	cause of
\ \	n: Th ficate n, pa	- 1	25. Was case referred to medical	idney	1)136	rce				1 □Yes	2 <b>N</b> O	1 □Yes	2 No	
5	sicia s cert irecto	) Be	examiner?	Hospital:	npatient 2 🗆	CD/Outnotion	+ 2000 O	ther		(Check only o		6 Dother (0	- 16.1	
5	g Phy er this eral d	n: To	27. Manper of Death	28a. Date	of Injury	28b. Time of	28c. Inj	ury at		28d. Describe		6 ☐ Other (Sperry occurred	ciry)	
5	ath. r: Affi	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	,	h, Day, Year)	Injury		ork? ⊒Yes 2. □	No					
DIVISION OF	er deg recto	Certification:	3 Suicide 6 Could not be determined	28e. Place	of Injury - At ho	me, farm, stre	eet, factory, office	)	- 1	28f. Location (	Street ar	nd Number or Ru	ıral Route Nu	mber,
5	Ital or Ital or Ital or Ital or Ital or Ital or	Cer								•				
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	ical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	miner: On the b	asis of examina	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date a	nd place, ath occurr	and due to the red at the time,	cause(s date an	s) and manner as d place, and due	s stated. to the cause	(s)
	the the smple	Medical	one)  29b. Signature and the of certifier	and mani	ner stated.		29c Lice	nse number			29d. Da	ite signed (Monti	h. Dav. Year)	
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•			30. Name and address of person who	completed cause	e of death (Item	23a) (Tvne I	Print)	ا صد	- (	` `			1	-
			William D.	Mul	onnel	16	301 N	· Ch	elea	5 13a	14	more	2121	7
	Sta Registra	-	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Lemenson FTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Season's Hospice Randallstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ★ M 2 🗆 F 02 01 83 Jamicia Director 220-64-7880 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extension must be rediffed at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location X☐Yes 2☐No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21215 U.S.A. Funeral 3513 West Garrison Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 6th grade mentary/Secondary (0-12) College (1-4or 5+) Carpenter Development Co. na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mauda Clemenson George Clemenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Md 21215 3513 West Garrison Ave, Joyce Clemenson-Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial A☐ Cremation 3 ☐ Removal from State On-Site 3/1/10 Baltimore, Md 4 Donation 5 ☐ Other (Specify) March F/H West of Funeral Service Licenaee Baltimore, Md 21215 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest, Immediate Cause (Final cisease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a conse juence of Examiner ll any leading to have de cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ➤ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe res 2 has certificate 2 No 1 □Yes 1 □Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 10 Other: 4 Nursing Home 5 Residence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other 1 Tes this After this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Certification: the Hospital or Attending (Month, Day, Year) Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death. the Funeral Director A the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled n by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ap 2

Stat

State Registrar

31. Date filed (Month, Ray, Year) 2010 State Registrar

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

**ORIGINAL** 

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

February 21, 2010

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

& JAG

Assistant Medical Examiner

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ cal Examiner	1. Decedent's Name (First, Middle,Last)  Judith Cole		2. Date of Death	3. Time of Death						
	0 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		Month Day Year February 22, 2010	1917 hrs						
		City, Town, or Location of Death	<del></del>	y of Death						
Funeral Director		If Under 1 Year If Under 24Hr: Months Days Hours Min		Birthplace (State or Foreign Country) Unik Virginia						
yland -f show any once.	Usual Residence of Decedent  10a. State	Of. Zip Code	10g. Citizen of What C	10d. Inside City Limits 1 Yes 2 No						
teath with the Maryland items 23a or 28a-f shust he notified at onc	2501 Madison Avenue, #810 2501 Madison Avenue #810	21217	USA	merican Indian, Black,						
ier d	1 X Never Married 2 Married Armed Forces? I Yes 2 No If Yes, 3 Widowed 4 Divorced Iff Yes, Give Year 1 Yes	es 2 No specify:	cify Cuban, Mexican, Puerto Rican, etc.) White, etc.							
Definition of the state of the	Elementary/Secondary (0-12)  College (1-4 or 5+)  unk  Clerica	of working life. DO NOT use ret $oldsymbol{1}$	IRS	unk						
Mental Hygiene. marked other than c event, the Medica To Be Comple	17. Father's Name (First, Middle, Last)  James Kenneth Cole  Lucy Blackmore									
12 should the and Mer tumatic even	19a. Informant's Name/Relationship (Type, Print )  O.G.M.E. Lucy Hill/ Mother  19b. Mailing A 111 P	ech Court, Smi enn Street Bal	EWTTe11. MD 21201	tate, Zip Code)						
vermit. Pages I and Department of Healt important: If item njury or other trau	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 20b. Place of Dispositio crematory or other		Date 20c. Location - City	or Town, State						
permit. P Departme Importat injury or	4 Donation 3 Monitor Specify. in State  21. Signature of Funers Gervice Licensee Lonald Sp. Wade, Trector  Conald Sp. Wade, Trector  Religions MD 21201									
hysician // edical miner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last									
and and	UNPENDED X AMENDED 9,11,15,16a-b,17 PII per ME g901	7,18,19a-b, per 3.11.10 TT	AB & 22, per DVF	t 8903 5/10/1€						
hysician: The law requires that the death certificate be ex this certificate has been signed by the attending physician al director, page 2 should be detached for use as the burial TO BE Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Featal	death 3 Ectopic pregna	23d. Date of delinancy Month	very Day Year						
gned by the detached by Phy	Part II. Other significant conditions contributing to death but not resulting in the und  Left breast abscess	erlying cause given in Part I.	23e. Did tobacco use contribute							
The law requires that it ficate has been signed by page 2 should be detacl	LEIL DIEAST ADSCESS			e autopsy findings available to completion of cause of 17 Yes 2 No						
ng Physician: The law requir After this certificate has been si meral director, page 2 should E n: To Be Completed	25. Was case referred to medical examiner? Hospital:	26.Place of Death (Check	only one)							
ng P	1 ✓ Yes 2 No 1 Impatient 2 Erroutpatient 3  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2	ry 28c. Injury at Work?	ng Home 5 Residence 6 ✔ 0	ther: Scene						
Suicide  Suicide  Could not be determined (Specific)  Security  Could not be determined (Specific)  Could not be determined (Specific)										
To the Hospit within 24 hour To the Funers completely fill Medical Ce										
Me is g s	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Monitoria)  February 23, 2010									
	30. Name and address of person who completed cause of death (Item 23a)	traat Baltimara MD 213	201							
	Laron Locke MD. Assistant Medical Examiner 111 Penn S	treet, baitinore, MD 212	.01	•						

DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 2010 5:46 A Marie Teresa Christian 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Pasadena 7740 Outing Avenue 8. Date of Birth (Month, Day, Oct 24, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Months Min. Days Hours 1 □ M 2 1 F 83 1926 Maryland 220-14-5473 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ∐Yes 2√ENo MD Pasadena Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 USA 7740 Outing Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 21 No Specify Specify: white 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk housewife own home unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Felix Ceaser Hebrank Elizabeth Agnes Olszewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21122 Elizabeth Templeton/niece 7740 Outing Avenue Pasadena, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S. Wade irector Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. List only one cause on each line. List only one cause on each line. Due to (or as a consequence of): Approximate Interval Between Onset and Death Due to (or as a consequence of): res len Silve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) I ☐Yes 2 XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part J. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

ò

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, its Modical Examinating to notified at once.

Baltimore, Maryland 21215-0036

ing physician and as the burial-trans cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Completed by certificate has within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

Division of Vital Records, P.O. Box 68760,

									- 1			
Mitna	l Rigi	ng,	itaka				_			24a. Was an autopsy performed?	24b. Were autopsy findings availa prior to completion of cause death? 1 ∐Yes 2 【▼No	
25. Was case referre	d to medical						26.	Place of Dea	ath (C	Check only one)		
		Hospital: 1   Inpatient 2   ER/Outpatient 3   DCA Other: 4   Nursing Ho						Home 5 KResidence 6 ☐ Other (Specify)				
27. Manner of Death 1 Manner of Death 2 □ Accident	-//	28	la. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes	2 □ No	280	I. Describe how injury	occurred	
2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine		28	e. Place of Injury - At h building, etc. (Speci	ome, farm, stree	et, facto	ory, of	fice		28f	Location (Street and City or Town, State)	d Number or Rural Route Number,	

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MAR 0 1 2010

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher deBoria
31. Date filed (Month, Day, Year) 3708 mountain 0

State Registrar

Medical

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year Feb 2:18P Wilma Maxine Crompton 26 Medical 4a. Facility Name (if not institution, give street and number)
Golden Living Center 4b. City, Town, or Location of Death
Westminster Examiner 4c. County of Death Carroll 7. Age (In yrs. last birthday) 80 yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 444-28-7536 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2-13-1929 Months Days Hours Min. Director Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shou other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 218 Kaywood Place Funeral with Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Š 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Credit Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leroy Head Opal Castleberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Schuster-niece 110 1st Ave West, Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Surial 2 Cremation 3 Removal from State 3-11-2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Signatur o Fineral Service Licens Homas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Alherusclawha Conhiberarch Cor Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred A Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 7/2009

only one

29b. Signature and title of certifier

PARIL MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2126/10

Westministr MD 21157

29c. License number

D43725

The certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			FOI	tate of Ma	ryland /	/ Depa	rtment of H	ealth and N	/lental Hyg	giene				
			_ State Registrar			Cen	tificate of D	eath		Reg. No.	MO	05706		
	Dhysisis	,	1. Decedent's Name (First, Middle, Last)		_				2. Date of Dea	ath Day 7	Year)	3. Time of Death		
	Physicia Medic		Potto C	100	cu	ar			Month 6	2 Day 2	1 601/	12:50A ^M		
	Examin	er	4a. Facility Name (if not institution, give street	and number)			4b. City, Town, or	Location of Death		4c. County of Death				
			Carroll Hospital ( 5. Social Security Number   6. Sex		In yrs. last b	a leth doud	If Under 1 Year	stminste If Under 24 Hrs.	r 1 8. Date of Birt		Carroll 9. Birthplace (State or Foreign			
	Funeral Director		215-26-8923			Yrs.	Months Days	Hours Min.	(Month, Day	, Year) 1928	Cou	nplace (State of Foreign Intry) Marvland		
			Usual Residence of Decedent		81				INOV. Z	1920	<u> </u>	ratytalu		
	shor dat	Þ	10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits		
	Mary 28a-1 otifie	irec	Maryland Frederic	ck			Unio	n Bridge				1 ☐ Yes 2 🙀 No		
	h the	a D	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	untry?		
	th wil	Funeral Director	11628 Houck Rd.	/as Decedent Eve	: 110	140.14	( December 115	21791			U.S.			
	r dea	by Fu	11. Marital Status  1 X Never Married 2 Married 1	13. V	as Decedent of His Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)		ice - Amer ack, White	ican Indian, , etc.				
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5	houn natur lical	Year or Dates.  15. Decedent's Education 16a.						tion		16b. Kind of	Business I	ndustry		
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7	ygien ygien her ti nt, the	seamstress cl										factory		
	State   10b. County   10c. City, Town or Location   10c. City, T										ne)			
Ž	12 should be fath and Menta 27 Is marked 12 tranmatic ev	Clarence Joseph Clabaugh  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta												
<u>8</u>	2 sho th an 27 is traus			·										
ď.	Heal Heal tem		Linda Frazier/ niece 20a. Method of Disposition	<u> </u>		of Dispos	32 Houck sition (Name of		nion Bri	20c. Location				
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	permit. Page Department ( Important: If any injury or once,	1	21. Signature of Funeral Service Licensee	1/2	/ Mecin		Name and Address							
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	Medical Examiner		resulting in death)	Due to (or as a	consequenc	ce of):						) /		
		<u>.</u>	Sequentially list conditions, b. —	Ren-	1 .40	<u>~, \ ~</u>	19				$\rightarrow$	twels		
	sit ed	nine	if any, reading to immediate cause. Enter Underlying	Due to (or as a										
,	ecute and I-tran	Exar	Cause (Disease or iinjury that initiated events c. — resulting in death) Last	Due to (or as a	consequence				· · · ·			-		
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X O O	death	Physician/M	1 Ves 2 No	Pregnant at t			Other (specify)			N	fonth	Day Year		
	t the by the	Phy	9 Unknown			a de Alan co		en in Dort I	00 8:11		1.25	the cause of death?		
Ţ.	es tha igned be de	by	Part II. Other significant conditions contribu	iting to death but	i not resultii	ig in the ui	idenying cause give	an in Faici.				robably 4 Unknown		
	equire een s een s	eted												
Records,	law r has b ie 2 sl	Completed							24a. Was autop		prior to death?	opsy findings available completion of cause of		
ř	i: The icate r, pag		25. Was case referred to medical	- 00			00.51	(5 11 (6)	1 🗆 Yes			2 No		
Z	siciar certif irecto	Be c	examiner?  1  Yes 2 No	tal:	+ 0 T ED	(O: += -+:	t 3 🗆 DOA Othe	ce of Death (Chec			(0	26.4		
	y Phy er this	e: To	27. Manner of Death	8a. Date of injury	28	b. Time of	28c. Injury	at	ome 5 🗌 Resid 28d. Describe h			(1)		
	nding ath. r: Afte e fun	icat	1  Natural 5  Pending 2  Accident Investigation	(Month, Day,	Year)	injury	M 1 🗆	? Yes 2 □ No						
VISION OF	er degector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 28	Be. Place of Injury building, etc.		, farm, stre	et, factory, office		28f. Location (S City or Tow		ber or Rur	al Route Number,		
2	ital or irs aft al Dir led in											l.		
	Hosp 24 hou Fune ted fil	Medical		n the basis of exa	amination an	d/or invest	igation, in my opinio	n, death occurred a	it the time, date a	nd place, and d	lue to the c	ause(s) and manner stated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 L Certifying Nurse Prace 29b. Signature and title of Certifier	ctioner: To the b	est of my kn	owiedge, d	eath occurred at the 29c. License			e cause(s) and r 29d. Date sign				
	FSFÖ		N	1.0.			00	1062	966	2 - 1	١٩.	10		
	,,		30. Name and address of person who comple	eted cause of dea	ath (Item 23	a) (Type, P	rint) Wi 11	our Kuo	.00	<u> </u>	) \	, -		
	H		JaT Stone	CAU	7 . (	NP	1 toning	\	いり	7115	8			
	Stat		31. Date filed (Month, Day, Year)	32 Registrar	's Signature	-								
	Registra	ir	#AR 1 2010	1/2 and	. 10	45	was 6							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** DOWER 1.00 AM MARJORIE 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Sykesville Fairhaven Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/14/1927 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 F 218-52-7804 Colorado Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygene.
Importent: If item 27 is marked other then "neturel" or liverany or other traumatic event 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Carroll Sykesville Md 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 USA 7200 Third Ave by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife 4yrs. Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle Dano Walter Mix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5169 Phantom Ct. Columbia, Md. 21044. David C. Dower (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State All County Cremation 02/25/2010 Sykesville,Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel P.A. 21. Signature of Funanch Service Licenses P.o. Box 195 Sykesville, Md. 21764. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR ALLIBENT days /Medical Due to (or as a consequence of): Examiner EGAL CARCINOMA HEPATIC METS WITH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed PULMONARY EMBOLISM physician a s the burial-1 Division of Vital Records, P.O. Box 68760, HYPERTENSION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by OSTEOPOROSIS 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? APTHRITIS RHEUMATOID 24a. Was an autopsy performed' certificate 2 No 1 Yes 1 Yes 2 No Be 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this tuneral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0061538 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 STONER AVE, STE 305-507, WESTMINSTER, MO PARIKH MD gistrar's Signature 31. Date liled (Morlth, Day, Year) 32. State MAR 0 1 2010 Registrar ann B. parle

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Frances Theodore Doxzon February 2010 6:56a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Sykesville 6414 Church Street 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours May 6 217-18-2813 88 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. MD Carroll Sykesville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 6414 Church Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: \$ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) domestic College (1-4or 5+) homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Grimm George M. Buckingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3427 N. Furnace Rd., Jarrettsville, MD 21084 Sharon Schuck (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 3-1-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee · Baige Haught Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Diseuse Alzheimer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year ☐Yes 2X No 5 ☐ Other (specify) been signed by the s should be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has trector, page 2 s autopsy performed: 1 ☐Yes 2 No 1 ☐Yes 2 No ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier h mano Imanoe!

State Registrar

DHMH 17 Rev 1/2001

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Babak Imanoel, Do; 218 washington Heights Medical Center; westminster, MD 21157

H53939

Do

32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 0 1 2010

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 20M 10 7 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs, last birthday, Min. Hours Months Days 1 □ M 2 XF 11-23-1928 Pennsylvania 81 208-22-8995 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 ☐ Yes 2 👿 No Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 1513 Taylor Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. □Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. White 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Audit Clerk Auto Leasing Firm 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Helen Hildebrand Robert Gill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, Maryland 21012 449 Shore Acres Road 1A Granddaughter Mrs. Ronda Haas 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Holly Hill Memorial Gardens 03-04-2010 4 □ Donation 5 □ Other (Specify) 5305 Harford Road 22. Name and Address of Facility 21. Signature of Gneral Servi Licensee Leonard J. Ruck, Inc. Baltimore, Maryland 21214 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

ed other than "natural", or items

marked other

2 should be fil h and Mental H ' is marked otl

Pages 1 and 2 s ment of Health an ant: If Item 27 is

permit.

Department of Health Important: If Item 27 any Injury or other troops.

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examine and burial-tran attending physician for use as the buria Physician/Medical the signed by t I be detach \$ Completed page 2 should certificate director, Be Certification: To After this funeral (

law requires that the death certificate be executed

Box 68760,

P.0.

Records.

Division of Vital

or Attending

Hospital

filled in by the

within 2

IF FEMALE 23b. Was decedent pregnant

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a, Certifier

Medical

4 Homicide

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes

1 hpatient 28a. Date of Injury (Month, Day, Year) 28h Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the dead of the dead of the dead of the dead of the cause(s) and due to the cause(s) and

and manner stated one) 29b. Signatur

5 Pending investigation

6 □Could not be

29d. Date signed (Month, Day, Year)

ate filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 3 Month Year Physician /Medical 1 moth 2010 FEBRUAR 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ₹ M 2 □ F Days 61 Kitts 7-8-1948 580-10-6660 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 1 Yes 2 □ No Director notified Glenn Dale MD Prince Georges 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ŏ USA 20769 must be 10901 Legend Manor Lane 23a and 2 should be filed within 72 hours after death v leatth and Mental Hygiene. m 27 Is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status the Medical Examiner 1 Never Married 2x Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Local Union 5 Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phyllis Anne Bridgewater Herman David 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10901 Legend Manor Lane Glenn Dale MD 20769 Department of Health a Important: If Item 27 Is any injury or other trau once. Christiana King-David/W. 5E 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Removal from State George Washington Cem 3-7-2010 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshalls Funeral Home 21. Signature of Funeral Service Licensee whia P. Marshall M60 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumocystis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last odeficiency Virus Exami The law requires that the death certificate be executed physician and as the burial-trans Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 | Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Kinpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 M No 1 🗌 Yes 2 ER/Outpatient 3 DOA ٩ After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P safter death.

I Director: After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide Could not be Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, within 24 hours a the Hospital completely

> F State Registrar

29b. Signature and title of certifier

Grum ber eiko MD e filed (Month, Day, Year)
HAR 0 1 2010 32. Begistrar's Signature

30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

MD

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

FeBRUARY 23,2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANNA 01:53 EBER WEIN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 😿 F Months Hours Min 10^M15[±]1929 216-24-8796 80 Marv Tand **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d Inside City Limits Director 1 X Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 5011 E. Hoffman Street items ; 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Force Black White etc ö 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lunch Aid School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be Antoinette Bianco Saverio Rosetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mr. Melvin S. Eberwein - Son 9636 Crystal Ridge Road Las Vegas, NV 89123 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite injury or 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 03-02-2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signal in of Funeral Service License 22. Name and Address of Facility 5305 Harford Road any Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or comp shock, or heard failure. List only or Immediate Cause (Final ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ne cause on each line VROSEPS Physician/ day disease or condition resulting in death) Medical Due to (or as a consequence of Examiner METABOL day Sequentially list conditions Examine cause (Disease or iinjury that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death 9 Unknown 9 Unknown P.O. à signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performe death? certificate 2 🗆 No 1 Yes Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1910 Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MOBULA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HO

4940

32. Registrar's Signature

DHMH 17 Rev 7/2009

29c. License number

EASTERN AVE BALTIMORE, HD

000

29d. Date signed (Month, Day, Year) FEBRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HANS WERNER FRITZE February 24,2010 2:19P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8147 Pleasant Plains Road Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) January 8, 1931 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1**XX**M 2□ F 213-34-1761 79 West Germany Director Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 □Yes WNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or 8147 Pleasant Plains Road 21234 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 (No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Tes 2 XXVo Specify: þ Specify: White 3¥XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pressman Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Werner Fritze Henne deHande ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathrvn J Fritze DTR 8147 Pleasant Plains Road Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial XX Cremation 3 ☐ Removal from State GreenMount Crematory March 1,2010 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service Ligensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the dis .. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final **Physician** Adenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ng physician and as the burial-transil Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be

Hospital or Attending Physician: The law requires that the death certificate be executed of Vital Records, Division within 24 hours after deat To the Funeral Director:

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Medical Certification: To

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. . 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

D38662

26/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4660 Walsh Kichard

Baltimore MD 21229 Wilkens Ave

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1 per doc. 8 per fh State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** John Lee Ford Sr. 24 9:30 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Season's Hospice Randallstown 8. Date of Birth 04Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 🔀 M 2 🗆 F 216-16-2662 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examirer must be notified at 1 ☐ Yes 2X No Director MD Baltimore Randallstown the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21244 U.S.A. death 3104 Mayfield Ave 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Y Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify Specify: Black þ 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during mo**Unkingwn** life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ni any injury or other traumatic event, If the Medianonce. Elementary/Secondary (0-12) College (1-4or 5+) NSA 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Benjamin Ford Sr. Martha Forbes P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pikesville, Md 21208 3815 Seven Mile Lane, Bernadette Crockett-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet 3/10/10 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21. Sign hard of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ate Cause (Final se or condition resulting in death) Atheroscientic cardiovascular **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No ned by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) PICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manyer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiet 29c. License number MS Rajapathe MID D0057465 2/24/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D. 2835 Smith Av. 5-203, Baltimore, MD. 21209-

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

10-01572 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Peg No. 2010 0571											571	
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Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under Months	1 Year Days	If Under 2 Hours	Min.		h(MM/DD/YYYY) 5-1981	oreign		
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any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Locatio	n						10	d. Inside	City Limits
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21. Signature of Fundial Service Licensee 22. Name and Address of Facility March East 1101 E. North Avenue Balto											1D 2	1202	
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Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	ပ	4 Homicide  29a. Certifier Check column 1 Certifying Physician:	To the best of my knowled	ge, death occurr	ed at the t	ime, date	and place	e, and d	ue to the caus	e(s) and manner a	s stated.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical	one) 2 Medical Examiner: Or an	the basis of examination a d manner stated.	ind/or investigati	on, in my	opinion, (	death occu	urred at t	the time, date	and place, and due	to the c	ause(s)	
F 3 F 3	Me	29b. Signature and title of certifier				License				29d. Date signed		, Day, Yea	ar)
		Henre Buthall. 1	UD			O.C.M	I.E.			February 22	2010		
<u> </u>		30. Name and address of person who com Pamela E. Southall, MD A	pleted cause of death (Item ssistant Medical Exa		Penn	Street.	Baltimo	ore, MI	D 21201				
	tate		32. Pegistrar's Signati										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 855 Physician Kenned 2010 FEBTUOLTU 25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ₹M 2 □ F Months Days 45 1964 20. Maryland 220-90-4880 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c City Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore City Maryland 10g. Citizen of What Country? 10e, Street and Number 6 items 23a 21211 USA 1363 Weldon Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
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Yes 2 □ No Specify: Mexican Baltimore, Maryland 21215-0036 ō White Specify: à 3 Widowed 4 X Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Furnishing & Lighting Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturer Self Employed/Proprietor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Gutierrez M. Theresa Shettle Roberto Τ. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Pers permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tran 1363 Weldon Avenue, Baltimore, Maryland 21211 Ms. Roya J. Golpira 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 2/27/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxic-**Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** metastruhl Sourioma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Tyes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury or Attending 1 ☐ Yes 2 ☐ No s after death. Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) end manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Itoma

MAR 01

31. Date filed (Month, Day, Year)

RESDOO

cbniary 25,2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Elizabeth Gorham 2010 8:40p 02 Anna Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Joseph Richey House If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Months Hours Min. Country) 1 □ M 2 🛣 F Yrs. Director 216-34-4107 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 21215 U.S.A. 3900 Cedardale Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12th grade (0-12) College (1-4 or 5+) 4yrs Woodstock Job Corp. Couselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jasper Williams Eva Joyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Cedardale Road, Baltimore, Md 21215 James L. Gorham Sr.-Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Crownsville, Md Crownsville Vet. 3/3/10 March F/H West 4300 Wabash Ave, 21. Signat are of Funeral Service Licensee ma Baltimore,_ 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic elanoma Physician 1ears disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d Date of delivery 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) n signed by the a ld be detached fo Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و و 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has t autopsy 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence Hospice 2 **1** No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending М 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier SO MD

State Registrar N. Eutaw St

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

32. Reg

SO MD

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arl Gross		State of Maryland / Department of Health and Mental Hygiene								
Physici	an/	Registrar	g. No. 3. Time of Death							
Pnysicii Medical Exami				2. Date of Death Month February 5,	Day Year					
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
		100 Revolotion # 402	Havre de Grace		Harford					
Funeral Director		5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	n(MM/DD/YYYY) 9. Birthplace (State or unk					
Bilector		I VI Z F	rs.	Jan 6,	1935 Country)					
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits					
	<u>_</u>	MD Harford Havr	e de Grace		1 Yes 2 No					
faryla: 28n-f:	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?					
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			Itimore MD 2120	0.1						
Physician /M		failure List only one cause on each line.	the mode of dying, such as cardiac o	rrespiratory arres	st, shock, or heart Approximate Interval Between Onset and Death					
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		Sequentially list conditions, b								
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ords, F w requires s been sign should be	lete			24a. Was an autopsy						
The law	Completed			performe	ned? death?					
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28. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28. Location (Street and Number or Rural Rundle)  28. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)										
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.								
F 3 F 3	ž	29b. Signature and title of certifier	29c. License number	1	29d. Date signed (Month, Day, Year)					
		Mayone melyhule	O.C.M.E.		February 7, 2010					
		Name and address of person who completed cause of death (Item 23a)     Margarita Korell MD. Assistant Medical Examiner 111 F	Ponn Stroot Raltimore MD (	21201						
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Penn Street, Baltimore, MD 2							
Regist		MAR 0 1 2010	A.S.		-1					

DHMH 17 Rev 1/2001

ORIGINAL

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of H	lealth and Me	ental Hygien	e	
			1 - State Certificate of I	Death	Reg. N	0.2010	05718
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	/Medic		Mary John		2 1	17 10	11.00am
	Examin	er		r Location of Death	1	c. County of Death	_
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	Prince Geo	rge's ace (State or Foreign
н	Funeral Director		459-52-5722 1	Hours Min.	B. Date of Birth (Month, Day, Yea June 19,	1932 Count Tex	ry)
	ъ		Usual Residence of Decedent				
	irytan show	<u>.</u>	10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	8a-f	Director	MD Prince George's Berwyn Heights				1 □Yes 2√□No
	vith th	Dir	10e. Street and Number 10f. Zip Code	20740	10g. C	Citizen of What Count USA	ry?
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evarine must be notified at	Funeral	3/12 Radour 50100		ih. Vaa ar Na	14. Race - America	n Indian
	ter de iner	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☑ Married 1.☐ Yes 2 ☑ No	an, Mexican, Puerto Ri	can, etc.)	Black, White, et	
980	urs af	by	If Yes, Give 1 ☐ Yes 2 № No 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:		Specify: Whi	te
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re,	s 1 a		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	(ce) Dat	te 20c.	Location - City or Tov	vn, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evanite must be notified at one.		21. Signatur Superior Licensee Formald S. Ware, Prector State Anat	omy Board	655 W. Ba	ıltimore S	treet
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated.				
	To the vithin To the compl	Me	29b. Signature and title of certifier 29c. Licens	se number	29d. [	Date signed (Month, L	Day, Year)
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	777	/ 4 0 -	,11	20700
			Sylph SADW (4333 Laural Bow)	e Kd.	X HULEL	- 1/1/2	X0 105
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 9 per Th, g901 Department of Health and Mental Hygiene Certificate of Death Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day ALLTSON GOEROLD Medical 2010 Februar 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 653-32-1082 1 □ M 2 🖾 F Davs 8-29-2004 Months USA Colorado Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director CO Golden 1 Ves 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 80401 USA 2171 Sawmill Gulch Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Goerold Elizabeth Lynne Hamler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2171\ Sawmill\ Gulch\ Rd.\ Golden,\ CO\ 80401$ Elizabeth 1 Goerold/mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 2-26-2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Marshalls Funeral Home 4217 9th St NW Washington DC 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Pow monia Medical Due to (or as a consequence of): Examiner Lymphoblastic Zyears Gmonth Acuke Sequentially list conditions, in the line in the cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Day Pregnant at time of death ed by the detached 9 Unknown 9 Unknown ate has been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform nin 24 hours after death. **the Funeral Director**: After this certificate I npleted filled in by the funeral director, pag 1 Yes 2 X No 1 X Yes æ Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24,2010 MD 0 37357 (DC February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah N Nirali 10 CENTER DRIVE, BETHESDA, MARYLAND 32. Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	/arylar 8a-f s tified	recto	MD	Baltir	more	Ra	andallst	town						1 ☐ Yes 2 🕅 No
	with the Ns 23a or 2 ust be no	Funeral Director	10e. Street and Nur 8514 Libe					10f. Zip Co	ode 211	.33		10g. (	Citizen of What Co USA	ountry?
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1	ried 2 🛣 Married 4 🗆 Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates.		lf.	as Decedent Yes, specify  Yes 2	Cuban,	Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)-	14. Race - Ame Black, Whit Specify: Caun	e, etc.
15-0	72 hou 1 "natu edical	nplet	(Spe	15. Decedent's E ecify only highest g			(Give ki		lone dur	on ring most of v	vorking	16b.	Kind of Business	Industry
72	vithin liene.		Elementary/Sec	conday (0-12)	College (1-4 or 5-	+)	Manag	NOT use rei B <b>er</b>	urea)			EZ	Z Storage I	Facility
	l be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (	(First, Middle, Last)					1	8. Mother's Yvonr	Name (First, Middle ne Thibidea	e, Maide LJ	en Surname)	
, Maryland	nd 2 should salth and N n 27 is ma er trauma			lame/Relationship ( Green/ Hus							Rural Route Numb 1stown, M			ip Code)
Baltimore,	Page 1 an nent of He ant: If iten ury or oth				☐ Removal from State	20b. Pla	ce of Dispos netery, crem Nation	atory or othe	of or place) tery	3-	Date -2-2010		Location - City of the Cod, MA	r Town, State
Balti	permit. Departr Imports any inji		21. Sign tune of Fu	ENDONE	N. Cely	li	92	200 Lib	erty	Road, F	andallstow	n, M		Balto. Co.
			shock, or hea	art failure. List only	nplications that caused one cause on each line.	the death.	Do not enter	the mode o	f dying,	such as card	liac or respiratory	arrest,		Approximate Interval Between _ Onset and Death
- 2	Priysician/ Medical	ì	Immediate Cause disease or condition resulting in death)	ion	a. left Due to (or as a	Lemis	plere	homo	eche	enc	storts	_		7 days
	Examiner		Localitation	ſ	Hyp.	e-teus	inde oil.							Unknown
	_ +	iner	Sequentially list co if any, leading to in cause. Enter Under	mmediate erlying	Due to (or as a	conseque	nce of):							
	cate be executed physician and s the burial-transit	Examiner	Cause (Disease or that initiated even resulting in death)	ts	c. Due to (or as a	conseque	nce of):			_	-			
20	be ex sician burial	edical I	,		<b>d</b> .					_				
8760	ifficate ng phy as the	Med	IF FEMALE:						-					
\$ ME/ Box 687	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was deceden in the past 12 1  Yes 2 9 Unknown	months?	23c. If yes, outcome of 1 Live Birth 3 4 Pregnant at 9 Unknown	2 🗌 Fetal o	death 3 🗌	Ectopic predother (spec					23d. Date of de Month	elivery Day Year
1 MM.	ires that the signed by detaction		Part II. Other signi	ificant conditions	contributing to death bu	ut not resul	ting in the ur	nderlying cau	ise give	n in Part I.				o the cause of death?  Probably 4 Unknown
) Division of Vital Records,	ne law requ e has beer age 2 shou	Completed by									pe	as an topsy rformed s 2 <b>X</b>	prior to death?	utopsy findings available completion of cause of
a F	ian: Tirtifical	Be C	25. Was case refer examiner?	rred to medical						<u>`</u>	Check only one)	3 Z <b>II</b>	110	
₹	hysic this ce al dire	은	1 Yes 2		Hospital:  1 Inpatie		R/Outpatien	t 3 DOA	_	4 L Nursir	ng Home 5 🗆 Re			cify)
i o	Attending Physician: The sr death. ector: After this certificate Iby the funeral director, page	cate	1 Natural 2 Accident	5 Pending	(Month, Day	, Year)	injury	M	. Injury a work?	aı ′es 2⊡No		e now in	jury occurred	
ivisio	or Atten after dea Director:	Certificate:	3 Suicide 4 Homicide	6 Could not	be 200 Place of Injur	ry - At hom	ne, farm, stre	et, factory, o	office		28f. Location City or 7	(Street own, Sta	and Number or Reate)	ural Route Number,
	e Hospital or n 24 hours afte e Funeral Dir bleted filled in	Medical	29a. Certifier (Check only one)	2 Medical Example 2	ysician: To the best of miner: On the basis of exirce Practioner: To the	kamination a	and/or invest	igation, in my	noinigo	, death occur	red at the time, dat	e and pla	ace, and due to the	cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and					29c. L	icense r	number		29d.	Date signed (Mon	th, Day, Year)
(					completed cause of de			rint)		928-84			02-24-2	
(6)	Sta	10	31. Date filed (Mor	y Timmon nth, Day, Year)	32 Registra		areene	_ 5+	, K.	ultimu,	e mb	21	201	
9	Registr				110 Some	J. 1	. 400	ilas						

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		•	1 - For Amend Item 25 tate of Maryland Den	artment of Health and N rtificate of Death	Mental Hygier	ne No. 2010 05721
	Physicia	an	Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
~~	/Medic	al	James Franklin Coamber	the Other Transport Country of Country		26,2010 09:10 1
	Examin	er	4a. Facility Name (If not institution, give street and number)  Loch Raven VA	4b. City, Town, or Location of Death Baltimore		c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		215-40-3866 15xM 20F 68 Yrs.	Months Days Hours Min.	Sept.1,1	941 Country) MD
	land DW		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
:	Mary	tor	MD Baltimore Ba	ltimore		1 □Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	illed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or Items 23a or 28a-f show ant, it e Medical Examirar must be notified at		7735 Baltimore Street	21224		USA
	Item:	Funeral	11. Marital Status  1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
93	rai", or	þ	3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □XNo Specify:		Specify:White
21215-0036	natui	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	dent's Usual Occupation hind of work done during most of work DO NOT use retired)	ding 16b.	Kind of Business/Industry
12	within ene.	duc	Concentrativisecondary (0-12)	rete Driver	_ A	rundel Corp
9 2	should be inflow within 7.2 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, it is Medical Examinar must be notified at	Be Co	9th 17. Father's Name ( <i>First, Middle, Last</i> )	18. Mother's Nam	e (First, Middle, Maide	en Surname)
/lan	snould be r and Mental s marked o umatic eve	10 B	Frank Gamber	Anna	Gillen	
	2 sho 2 and l is ma rauma			ng Address (Street and Number or Ru		
e .	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Annie Gamber /wife 773  20a. Method of Disposition 20b. Place of Disp	5 Baltimore St		Location - City or Town, State
jou	rages nent of int: if its iry or o		cemetery, cre	matory or other place) Crematory 3/2	1	altimore MD
	permit. Pages Department of Important: If it any injury or o	İ				ve. Balto. MD
m i	B B E B		Mutally south	Connelly Funera		
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death
	xaminer		Do to (or as a consequence of):	alure		
		ner	If any, leading to immediate . Draw to (order a consequence of):	MINI C		
di de	and -transi	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C			
8760,	one be executed only sician and the burial-transit		Due to (or as a consequence of):			,
ox 68760,	g phys	edical	d			
ŏ	attending p for use as	M/ug	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
O. Bo	0 0	Physician/Me		Other (specify)	<del></del>	Month Day Year
J. 1	been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Vital Records,	n sign	d by	Alcohol Abuse, Failure to T	- 1	1X Yes	2 No 3 Probably 4 Unknown
000	as bee	plete			24a. Was an	24b. Were autopsy findings available
<u>x</u>	ate h	Completed			autopsy performed? 1 □ Yes 2 🔼	prior to completion of cause of death?
VITa iclan	sertific ector,	Be (	25. Was case referred to medical examiner?	1	th (Check only one)	
o å	r this	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Magner of Death 28a. Date of Injury 28b. Time of Death		ome 5 Residence	6 ☐ Other (Specify)
on E	ath.	atior	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	Edd. Dodding flow in	ary oddariod
DIVISION Lor Attending	rector	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
בֿ בַּ	urs aft					
Hos	within 24 hours after death.  To the Funeral Director: After this certification of the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director, to make the funeral director of the funeral director.	Medical	29a. Certifier (Check only  Medical Examine: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
Į,	within To the	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
			Menitul & L. Roll	D0069441	2	126/2010
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	2 11	nave MD 21218
	Stat	e	31. Date liled (Month, Day, Year) 82. Registrar's Signature	och Kaven BIVO	2, Dalth	have MI) 21218
	Registra	ar	31. Date liled (Month, Day, Year) 82. Registrar's Signature FEB 26 2010 Server 9. 400	Ked		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For Amend Items 25,27,28a-f per me g905,07/07/2010dhb

Registrar Reg. No. 2010 05722 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 1044 23 2010 Horring Hewett Lawrence Harry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Min. Months Days Hours **W**M 2□ F North Carolina 92 06-15-1917 Director 248-18-2074 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Experience must be motified at 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 903 Princeton Terrace 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 ∐Yes 2 No Specify: If Yes, Give Year or Dates: 40-45 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 sho. Id be filed within nent of Health and rental Hygiene. Dredge Boat Cook Water 6 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Cornelia Milligan Charlie Hewett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 is Mrs. Judith Faye Grimes 903 Princeton Terrace Glen Burnie, MD 21060 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 2/24/2010 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Mb1220 112 Singleton Funeral & Cremation Services, PA Approximate Interval Between Onset and Death 23a. f art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 065 **Physician** disease or condition resulting in death) Dyeny /Medical Due to (or as a consequence of): Examiner month renge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): CENTERCATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed use as the burial-transit traitme and resulting in death) Last Due to or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year signed by the a d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No icate has been si , page 2 should t Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐Yes 2 1 ☐ Yes 2 ☐ No Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA Certification: To ğ this Date of Injury 28b. Time of Injury **P** completely filled in by the funeral 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation 2 Accident Subject slipped and fell. 02/20/2010 1 ☐Yes 2 🛣 No death. Unknown within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1190 Monie Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Home Odenton, MD the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number s of person who completed cause of death (Itam 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0-01311 hillip G Holland	Please Type or Print in Black amend #9, Type or Print in Black State of Maryland / [ 1-For State Registrar	ck Indelible Inko Ensure All Copie er And Copie Department of Health and Mental Hi Certificate of Death		05723
Physician/ ledical Examiner	Phillip G. Holland		Reg. No.  2. Date of Death  Month Day Year  February 13, 2010	3. Time of Death 1037 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	

		1- For State Registrar	ertificate of Death	,,,	2010 eg. No.	05/2
Physi Medical Exar		1. Decedent's Name (First, Middle,Last) Phillip G. Holland		Date of Deat     Month	h Day Year	3. Time of Death
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Do	February 1	4c. County of Death	1037 hrs
Funera		Johns Hopkins Hospital  5. Social Security Number unk 6. Sex  7. Age (In yrs.	Baltimore			
Directo			Months Days Hours	Min	h (MM/DD/YYYY) 9. Birt Cou	hplace (State or Forei
		Usual Residence of Decedent	Yrs.	Jan 6,	1949 Nort	th Carolin
ow any			y, Town or Location			10d. Inside City Limit
faryland 28a-f show	غ ا	MD 10e. Street and Number	Baltimore			1 X Yes 2 N
ith the Maryland 23a or 28a-f sho	Director	300 E. Madison Street	10f. Zip Code 21202	10	g. Citizen of What Coun USA	try?
h with	Funeral	11. Mantal Status 12. Was Decedent Ever in U	J.Sun 1 13. Was Decedent of Hispanic Origin?	( Specify Yes or No-		an Indian, Black
er deat			If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	White, etc.	and the second
ours aft stural"	À P	or Dates:	1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind	of work dans1	Specify: whi	
16 n 72 h isan "n;	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use	retired)	166. Kind of Business/in	^{idustry} unk
-003 d withi giene. ther th	ह	unk 17. Father's Name (First, Middle, Last)				
21215-0036 hould be filed within 7. Ind Mental Hygiene, is marked other than stic event, the Medical	Be		unk 18.Mother's Na	me (First, Middle, Ma	aiden Surname)	un
	6		19b. Mailing Address (Street and Number of	or Rural Route Numb	er, City or Town, State	Zip Code)
2 H E R			19b. Mailing Address (Street and Number of 1905) Montka Place 1111 Penn Street Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Baller Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Balleler Baller			
Baltimore, permit. Pages I as Department of Hee Important; If ite		1 Burial 2 Cremation 3 Removal from State	crematory or other place)	Date	20c. Location - City or T	own, State
Baltimo permit. Page Department of Important; injury or ott		4 Donation 5 X Other Specify: in state  21. Sign of Fun envice Lice	22. Name and Address of Facility			
		onald 8. Director	Baltimore, MD 212	81 ^{655 W}	Baltimore S	treet
Physician /Medical		Part I. Enter the dilease, of control cations that caused the death failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Asphyxia by hanging  Due to (or as a consequence of	r):			Death
	<u></u>	Sequentially list conditions,   b     if any, leading to immediate   Due to (or as a consequence of				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C.				
uted id ansit		events resulting in death) Last  Due to (or as a consequence of d.	):			
Box 68760, -death certificate be executed he attending physician and of for use as the burial - transit	Medical	UNPENDED AMENDED				
3760, fficate be g physic s the bur		IF FEMALE: 23c. If yes, outcome of pregn 4. Like both to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	pancy		23d. Date of delivery	
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	Physician.	1 Yes 2 No 9 Unknown 9 Unknown				
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the hours after death. Funeral Director: After this certificate has been signed by lely filled in by the funeral director, page 2 should be detach	Ď	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.		cco use contribute to the	
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ospital hours uneral y fillec		4 Homicide determined (Specify) Jail/Penal		or Town, State 300 East Madison	e) n Street, Baltimore, M	ID
To the H within 24 To the F complete	Ġ.	(Check only one) 2 Medical Examiner: On the best of my knowledge	e, death occurred at the time, date and place, and d/or investigation, in my opinion, death occurred a	d due to the cause(s)	and manner as stated.	auco/c)
5.25.8	ŝ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	
,		dunnt/1	O.C.M.E.	i	ebruary 14, 2010	
		30. Name and address of person who completed cause of death (Item 2: Zabiullah Ali, M.D. Assistant Medical Examiner	•			
Sta	ite :		111 Penn Street, Baltimore, MD 21	201		
Registr		MAR 0 1 2010 Genera S.	pare			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c 22 per fh g901 3-8-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Month **Physician** Day Year HART 9:05 PM 07 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN HOSPITAL BaLTIMOR E If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign
Country) 1□M 2**√** 218-28 -432 Director 1927 June 7, Washington DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examination to periodified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3030 Pinewood Avenue 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: 2 Specify: White 3K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housekeeper YMCA permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event ang. 18. Mother's Name (First, Middle, Maiden Surname)

Jane O'Connor 17. Father's Name (First, Middle, Last) Be John Jacobsen ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 Pinewood Avenue Baltimore, MD 21214 Phyllis Hart/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖽 Other (Specify) Final Journey Crem. 3-5-10 Woodbine, Md. 21. Signature of Funeral Stryice Licensee Ronald S. Wadt Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Strategy and Cremation Services P.O.Box 1413

23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate Cause (Fig. 1) Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate perform 2 **2** No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA neral Director: After this filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar

29b. Signature and title of certifier

anis 31. Date filed (Month, Day, Year)

un be

MAR 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tan's Bumber, 5601 Loch Raven

2. Registrar's Signature

DHMH 17 Rev 1/2001

the

29c. License number

Resooo

5601 LOCH RAVEN BLUD, BaLTIMORE, MD, 21239

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician February 16, 2010 10:30 Johnny Ingram /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Medical Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Min. 1 M 2□F Days unk 19, 53 1956 212-88-5784 Dec Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County r items 23a or 28a-f shov incr nust be notified at 1 ☐ Yes 2√ No Directo DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20020 USA 1285 Otis Street NE by Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? arried 1 □ Yes 2 □ No u Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2X No other traumatic event, the Medical Exam If Yes, Give Year or Dates: Specify: Specify. b1ack 3 Widowed 4 Divorced natural" Completed unk unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) pe ဥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Hospital Drive Cheverly, MD 20785 Prince George's Medical Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 🕅 Other (Specify) state in 21. Signature of Funeral Service Licensee Ronal d S State Anatomy Board 655 W. Baltimore Street once Director nn 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner 1am-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a conseque Examine The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequency of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 ∏Yes 2 ∏No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy coa 2X No 2)2No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐Yes 2 ☐No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 30. Name a George Haspital Chereoly, 31. Date filed th, Day, Year) 2. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per dr., g901,03/01/2010dhb Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ Year Elizabeth anice 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4b. City, Town 4c. County of Death Hospital oseda Square center MDI If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days 68 Months Hours Min **Director** Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2908 Rosalie 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify. Maryland 21215-003 3 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Krivate Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Eirst, Middle, Maiden Surname) ည Delegver ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 Rosalie Baltimore, Maryland Jones Avenue itusband Baltimore, 20b. Place of Disposition (Name of cernetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ballimore, Maryland 21. Signatur on uneral fervice Licensee 22. Name and Address of Facility 23a. Part 1. Enter the cise se, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory
Due to (or as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner Atherosclerotic cerebrovascu Score tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Yes 2 No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Dementia Hypertension 24b. Were autopsy findings available 24a. Was an has autopsy performed prior to completion of cause of death? Director; After this certificate 2 No 1 Yes Yes 2 No 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 🗌 Yes 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tive of certif 29d. Date signed (Month. Dav. Year) D2960 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Prive, Baltimore My, 21237 13 KCIGMAN MD 20

State

Registrar

31. Date filed (Mor

EB 26

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2225 Physician/ Jackson Virginia feb Helen 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Union Memorial Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Numbe **Funeral** Months (Month, Day, Year) Hours Min. Country) 1 ☐ M 2💢 F NC 93 Yrs 215-24-4963 Director Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location 10a. State death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No Baltimore MD NA 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21225 152 Reedbird Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 🗓 No Specify: Black 3 Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the N House Housewife na 11th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bertha Lester Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md 21202 Baltimore, 904 Stubblefield Lane, Lyberian Massey-Daughter Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ott
once, cemetery, crematory or other place) 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 2/27/10 Woodlawn, Sign Ture of Funeral Service Licensee March Address of Eacility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death mediate Cause (Final Severe Sepsi Due to (or as a consequence of): Physician/ days disease or condition resulting in death) Medical Examiner years ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examine 20 Mellit years requires that the death certificate be executed attending physician and for use as the burial-transil ighetes that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ŽÜnknown Division of Vital Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death. Funeral Director: After this certificate has b autopsy page 2 performed? Yes 2 No 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb, 20, 2010 38946

State

Registrar

DHMH 17 Rev 7/2009

31 Date filed (Month Day Yes

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istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22:00PM 660 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dav. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday Year 08 059 - 94 - 347747 62 Pakistan Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 □ No NA Baltimore MD 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number 614 Walker Ave Apt B 21212 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 X Married 1 ☐ Yes X☐ No Specily Asian Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 4yrs Elementary/Secondary (0-12) 12th grade Housewife House 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nusrat Ali Amina Bibi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mohammad A. Sainsara-Husband 614 Walker Ave Apt B, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 TRemoval from State Gujianwala 4 ☐ Donation 5 ☐ Other (Specify) 3/5/10 Pakistan Gharbi 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March Funeral Home West 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition equal to in its death). Respiratory Arrest Arrest 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between resulting in death) Due to (or as consequence Seizure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Crutzfield-Vacob Disease resulting in death) Last Due to (or as a consequence of) IE FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? No 2 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner Other: 4 $\square$ Nursing Home 5 $\square$ Residence 6 $\square$ Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 1 Inpatient 3 DOA 2 ER/Outpatient 28d. Describe how injury occurred

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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items 23a

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"natural",

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health an
Important; If item 27 is
any Injury or other trau

traumatic event,

the Medical Examiner must be notified at

**Funeral Director** 

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Completed

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed bunial-transit and attending physician the use as within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

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	nysician/Medical
	by Physic
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	ication: 1

To the Within 2

29a. Certifier (check only Medical one) 29b. Signature and title of certifie

State

Registrar

Certif

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 3 
Suicide

4 - Homicide

6 Could not be determined

0

28a. Date of Injury (Month, Day Year)

and manner stated

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 🗌 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

M.O eted cause of death (Item 23a) (Type, Print) who comp 30. Name and address of person

HOL linson 31. Date filed (Month, Day, Year)

Registrar's Signature

DHMH 17 Rev 1/2001

Amend PI 1ine Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI 1ine a-b, per MD g901 3/1/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year **Physician** DUGLAS 16 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Ac. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 XIM 2 □ F Yrs. Director 219-60-9741 57 2,1953 Jan. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Examiner must be notified MD Baltimore Baltimore County 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö items 23a United States 613 46th Street Funeral 21224 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify ģ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Music Industry Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Hygiene. Entertainment Karaoke/DJ 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental John Henchey, Jr. Emily Webb ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health an Important: If item 27 is any Injury or other trau 613 46th Street Baltimore, Maryland 21224 Mrs. Brenda Church (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Hilltop Service Corp. 2/22/2010 Towson, Maryland ↓ □ Donation 5 □ Other (Specify) 21. Sign Ture of Funeral Service Lice Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 232 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac arrest **Physician** disease or condition resulting in death) CAROLAL /Medical Due to (or as a consequence of) Examiner Infected Aortic Root Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2,425 Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 2 No 1 TYes 2 No 1 Yes certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending After 5 Pending investigation Injury ours after death.

eral Director: Af
filled in by the fu death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On/the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only Medical one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ES-000 Druaky 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) Registrar's Signatur State MAR 01 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Patricia Lynn Klaput 1313 Physician/ Month Day 20 WILL Medical 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death and number **Examiner** 4c. County of Death ntrensitu Maryland 6. Sex **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Couptry) Maryland 1 □ M 2 🛣 F June 24, **Director** 217-62-4525 58 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21048 2323 Pin Oak Drive U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Armed Forces?
1 ☐ Yes 2 No Black, White, etc. ò 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 No Specify. If Yes Give 3 Widowed 4X Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -12Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Grover Conrad Caroline Hughes 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr John Klaput Former Spouse 2664 Jessamine Way York PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2x Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 2/20/10 Hampstead, MD 21. Signatu of Fund ral Service Lic 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 234 Part 1 Enter the Approximate Interval Between Immediate Gauss (Fi disease or condition Onset and Death Physician, Static Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause Disease or impury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Box 68760 the as use Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown ρ Pregnant at time of death Month Day Year detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home \(5 \sum_{\text{Residence}}\) Residence \(6 \sum_{\text{O}}\) Other (Specify) 2 X No 1 🗌 Yes ပ 1 Npatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work? 1 🗌 Yes 2 🗌 No Accident 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 [ 3 [ within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State Registrar 2010

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010	05732
	Dhomisi		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year	. Time of Death
	Physicia /Medic		Charles Edward Reserver	2:00 P M
1	Examin	er		
100			2259 Ady Road Forest Hill Harford  5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace	e (State or Foreign
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	Director		Usual Residence of Decedent	11821114
	yłanc how		100.0100	Inside City Limits
	a-f s	Director	MD Harford Forest Hill	1 □ Yes 2 No
	or 28	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	·
	ath w			
	er de itema	Funeral	11. Marital Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No- Armed Forces?   13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   14. Race - American I Black, White, etc.	ndian,
215-0036	ırs af	by	3 National Argument Argument Argument Specify: Specify: White	<u> </u>
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and	ould be filed v Mental Hygie iarked other i atic event, to	æ		
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re,	s 1 ar of Hea item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town,	State
altimore,	nit. Pages artment of I ortant: If ite injury or o		4 \ \ Donation 5 \ □ Other (Specify)	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fineral Structure Winds Director  State Anatomy Board 655 W. Baltimore Structure Baltimore, MD 21201	eet
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	pproximate terval Between
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	/Medical		resulting in death)  Due to (or as a consequence of):	11 0 1146
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	xecul and	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	ALS TEARS
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Вох	eath certific attending p for use as	N/ue	F FEMALE:  23c. If yes, outcome of pregnancy  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  23d. Date of delivery	V
	<b>Physician:</b> The law requires that the death certificate thas been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?    The past 12 months   The past 12 months   The past 12 month    y Year	
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Records,	: The law cate has t	Completed	24a. Was an autopsy prior to comple death?	etion of cause of
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of	g Phys er this eral dii	$\vdash$		
ion	nding F ath. r: After e funeri	ați	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
Division	If or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Record Description of the City or Town, State)	oute Number,
Ö	Ital or Irs aft ral Dir Ied in	Cer	ů de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de l	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 4 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	e cause(s)
	To t To t	X		
			30. Name and address of person who completed cause of death (Item 23a), (Type Hint), 1716 HARFORD Rd Su 105 FAUST.	5NHN 2104
	Sta	te	a 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1-10
	Registr	_	his constant his hard	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:15PM E. Kitchings Audrey EBRUAKY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital P.G. LANHAM 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F 578-54-7677 Months Days Hours Min. 0 3 Month Day Year 4 0 69 Director Washington, D Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at by Funeral Director 10d. Inside City Limits Capitol Heights 28a-f 1 X Yes 2 ☐ No P.G. MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 20743 J.S.A. 6905 Valley Park rd 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 ☐ Divorced Spec Black Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) private Elementary/Seconday (0-12) 12th College (1-4 or 5+) Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Chambliss Katie Atkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Voundy-Thomas/Niece 6905 Valley Park Rd. Capitol Heights 20734 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington Nat'l 03-15-2₀10 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 22. Name and Address of FacilityRonald TaylorII Fu 08 W. North Ave. Baltimore, md W. North Ave. 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death SEPTICEMIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Day g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown EREBROVASCULAR 24b. Were autopsy findings available prior to completion of cause of death? ACCIDENT 24a. Was an has autopsy performed? Yes 2 certificate I 2 🗆 No 1 Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LUCK KOND

State Registrar Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/u Van Le	State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Reg. No. 2010 05734
Physician/	Registrar 2. Date of Death 3. Time of Death 3. Time of Death
Medical Examiner	Vu     Van     Le       4a. Facility Name (if not institution, give street and number)     4b. City, Town, or Location of Death    Acc County of Death
	Prince Georges Hospital Center  Cheverly  Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)  Months Days Hours Min. Manuals 20, 1069
Director	5. Social Security Number 220-06-4102  1X M 2 F  7. Age (In yrs. last birthday) 41 Yrs.  1 Var. Months Days Hours Min. March 30 1968  March 30 1968  Yietnam
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
≱	MD Howard Columbia 1 Yes 2 No
the Maryland a or 28a-f sh tiffed at once Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
h the N 3a or sotified	5977 Turnabout Lane 21044 USA  11 Morital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-
r death with or items 23 must be no Funeral	11. Theyer Married 2 Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
fter de l'', or ner mu y Fu	The variation of the latest states and the variation of Divorced liftyes, Give Year or Dates:  1 Yes 2 No specify: Specify: Vietnamese
nours aft natural" Examine	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
5-0036 ed within 72 hour lygiene. to other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 engineer  engineering
5-00 ed with tygiens other	17. Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Malden Surname)
121; d be fill ental F arked went, 1	Hai Van Le  Canh Thi Ta  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ID 21 2 should and Mee 27 is man To	Karen Le (sister) 5080 Jericho Rd., Columbia, MD 21044
e, N l and 2 Health litem 3	20a. Method of Disposition
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  To see the remain of the Medical Examiner must be notified at once, to other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Columbia Mem. Park 2-27-10 Columbia, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries
LXaiiiiiei	or condition resulting in death)  Due to (or as a consequence of):
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ted misit	cause. Enter Underlying Cause (Disease or Injury that mitated events resulting in death) Last  Due to (or as a consequence of):
Box 68760, e death certificate be executed the attending physician and cd for use as the burial - transit hysician/Medical Exa	d
0, e be execut ysician and burial - tra	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
3876 rtificat ling phy as the	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day  Year
box 68760, the death certificate by the attending physiched for use as the buphysician/Mee	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the build but the page 2 should by Physician/Med	
b, P.O. ires that the signed by the deteche	
Records,   The law requires ficate has been sig yage 2 should be Completed	autopsy prior to completion of cause of
	1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
ital sician: sician: is certificator	examiner? Hospital: 4 Inpatient 3 POA Other:    Hospital: 4 Input   Postion
of Vital Records ing Physician: The law requi After this certificate has been inneral director, page 2 should inn: To Be Complete	27 Magnet of Doub 28a Date of Injury 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion ttendii death. etor: A y the fu	Natural 2 Accident   Pending Investigation   Feb 17, 2010   2048 hrs   1 Yes 2 No   Pedestrian struck by auto   Pe
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the hours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.  Certification: To Be Completed by P.	28e. Place of Injury - At home, farm, street, factory, office building, etc.  Suicide 6 Could not be determined (Specify) Major Road / Highway  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Baltimore Avenue and Willow Street, Laurel, MD
O Tile to Sp.	
To the Ho within 24 To the Fu completed	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  20b Signature and title of certifier.  29d. Date signed (Month, Day, Year)
<b>A</b>	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E. February 18, 2010
	30. Name and address of person who completed class of beath (Item 23d)
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat Registra	
DHMH 17 Rev 1/2001	UGINE
	*·**···

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 05735 For State Registrar Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2010 ear February 25, **Physician** 10:20 AM Ramona G. Lipka /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Good Samaritan Nursing Center Months Days Hours Min. 8. Date of Birth 09-28-1939 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** West Virginia 1 ☐ M 2 🕱 F Yrs. 70 Director 232-60-6035 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10h County 10a State Hygiene. other than "natural", or Iteme 23a or 28a-f ehow ont, the Modical Examinar must be notified at 1 X Yes 2 No Baltimore Directo N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 2825 Fleetwood Avenue Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Hame Homemaker 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fi of Health and Mental F I Item 27 is marked ot r other traumatic ever Dorcas Williams Ralph Kuhn ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21214 2825 Fleetwood Avenue Mr. Thomas S. Lipka - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If Ite eny Injury or ott 1 

Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial 03-01-2010 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Illun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCEN Immediate Cause (Final disease or condition resulting in death) Meta **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physicien and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown ete has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 3th known Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24e. Was an autopsy 1 ☐ Yes 2 1 NO certificete After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 🗆 A 3 🗆 S 4 🗌 H

Division of Vital Records, Director: / filled in by ö To the Hospital within 24 hours a To the Funeral Completely filled

2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, facto	ery, office		(Street and Number or Rural Route Number, own, State)
29a. Certifier (Check only one)	1 ☐ Certifying Physi 2 ☐ Medical Examin	cian: To the best of my know er: On the basis of examinati and manner stated.	rledge, death occurre on and/or investigation	d at the time, date on, in my opinion,	and place, and due to the	e cause(s) and manner as stated.  a, date and place, and due to the cause(s)

Tenne C. Bahn MD

D DS857U February 27, 2010 ype, Print) 5601 Loch Raven Blud 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrance L. Baker MD

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Registrar

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2010 12:30 P M February David Aloysius Lyons /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Harmony Hall Columbia If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 113-05-1791 New York Director May 16, 1910 99 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be motified at 1 ☐ Yes 2X No Director Columbia MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 USA 6336 Cedar Lane #383 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. filed within 72 hours after 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify. 2 Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "ne any Injury or other traumatic event, If I Mestical. Elementary/Secondary (0-12) College (1-4or 5+) 8 brakesman railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type. Print) Anton Haug/son 2530 Kensington Gardens #205 Ellicott City, MD 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) Kona d S. Wade, State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** RCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed 01 and burial-trar Due to (or as a consequence of) ned by the attending physician detached for use as the burla P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 22 No 2 🗆 No To the Hospital or Attending Physiclan: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation

State Registrar 2 ☐ Accident

3 Suicide

29a Certifier

Medical

4 Homicide

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 ☐ Yes 2 ☐ No

IN Rd ELKRING

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			For	Type or Prin			<b>delible Ink.</b> artment of H					•	
		ľ	1 - State Registrar			Cei	rtificate of	Death			Reg. No	2010	05737
	Physici	an	Decedent's Name (First, Middle, Las.      MADONIA C. F. LIDEN	,						2. Date of De	eath Da	y Year	3. Time of Death
	/Medic	al	MARTHA O. LUBEI				# 07 T		- ( D 4)-	F-eb	2.3		3-30PM
	Examin	er	4a. Facility Name (If not institution, give GENESIS ELDERCARI	E LOCH RAV		A Link L	PARKV.	4b. City, Town, or Location of Death PARKVILLE  If Under 1 Year   If Under 24 Hrs.				BALTIM	ORE
Ŀ	Funeral Director		5. Social Security Number 6. Se 214-05-3399  Usual Residence of Decedent	TM OF XE	100	est birthday) Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 9/3/19	ay, Year)	) (	rthplace (State or Foreign country) OTLAND
	death with the Maryland ms 23a or 28a-f show r must be notified at	tor	10a. State 10b. County BALTIMO	RE	10c. City, Town or Location TOWSON							10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	th the or 28a e noth	Jirec	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What C	ountry?
	23a ust b	ral	1644 MUSSULA ROA				212					USA	
36		by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ※Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 No	rigin? (Spe in, Puerto :	ecify Yes or No Rican, etc.)	0-	erican Indian, ite, etc. WHITE		
5-0036	2 hou atura cal E		15. Decedent's Ed	ucation	- 1	16a. Dece	dent's Usual Occur	oation	_4 _4		16b. K	Kind of Busines	s/Industry
21212	filed within 72 hours after Hygiene. ither than "natural", or ite ant, the Medical Examine	Completed	(Specify only highest grade Elementary/Secondary (0-12)  12TH GRADE		completed)  College (1-4or 5+)  (Give life.  Cl			during mos d)	st of worki	ng	IN:	SURANCE	
Maryland	be sd o	To Be (	17. Father's Name (First, Middle, Last) WILLIAM ORR						(First, Middle HUNTER	e, Maidei	n Surname)		
lar)	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7				ing Address (Street						Zip Code)
≥ ئە	s 1 and 2 of Health a ltem 27 is		ISABELLA WILLARD/	DAUGHTER	20h BI		MUSSULA	ROAD		SON, MI		1286 -ocation - City o	r Town State
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee MOO2 17				vood CEMETERY 2/27/2010  22. Name and Address of Facility THE JOH			/2010	BA	LTIMORE	, MD
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Division or	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		y Year)	28b. Time of Injury	M 1□	Yes 2	]No	28d. Describe			Cont Conta Musica
N N	oltal or Attencurs after death real Director:		4 Homicide determined	building, et	tc. (Specify	·)	treet, factory, office			City or Te	own, Sta	ite)	Rural Route Number,
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			30. Name and address of person who	93	26	tung	Fee for D	Dr	11/	Poc	kal	1/2 1	5 20 (0 (DZSS50
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	rars Signal	ture A.	back	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Frederick ML center 18W If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 1 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Martical Evantinar must be notified at 1 ☐ Yes 2 X No Westminster Carrol1 MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21157 108 Liberty Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Baltimore, Maryland 21215-0036 Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) shoe factory College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. machine operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cleo Eads Harold W. Cheeks ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 605 W. Myrtle St., Littlestown, PA 17340 Sharon Lentzner (sister) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-28-10 Sykesville, MD All County Cremation 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** >5/5 disease or condition resulting in death) 50 /Medical Due to (or as a consequence of): Examiner avdrowyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence sician and burial-transit certificate be executed Exami Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month 5 Other (specify) ☐Yes 2 No signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ yes 2 No 2 🗆 No 1 □Yes Division of Vital ospital or Attending Physician; TI hours after death. Inneral Director: After this certificate yfilled in by the funeral director, pa 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

within 24 hours a To the Funeral D

State Registrar

31. Date filed (Month, Day, Year)

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MID

2

Name and address of person who completed cause of death (Item 23a) (Type, Print)



Dr Frederick MI

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and Mental Hygiene																
			Registrar  1. Decedent's Name (First, M						tificate of Death				Reg. No. 2 1 1 5 7 3 9 Death 3. Time of Death				739
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Midd William O. L		hoow				l _I	18. Mothe	er's Name	e (First, Middle, ckett	Maiden	Surname)			
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6876	rtificat ing ph e as th	Mec	IF FEMALE:														
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician February Viola 2010 /Medical Mary Martin 24 12:48A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Social Security Number 6 Sex 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, Year) Days 1 □ M 2 □ 37 Yrs 91 Director 216-03-8508 July 14, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1KNYes 2 □ No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 45 Washington Rd. Funeral 21157 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 clerk retail store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Pezzica ျှ Maria Mirto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Mannone/ niece 3821 London Bridge Rd. Sykesville, MD 21784 permit. Pages 1 a Department of He Important: If Item any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 3/1/2010 Sykesville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home affarine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Bluteral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Advancel Equantially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Vital 1 ⊡ Yes 2 No 1 ☐ Yes 2 □No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral D e Funeral D etely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who co

31. Date filed (Month, Day, Year)

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o completed cause of death (Item 23a) Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^D33 Month BOID **Physician** HNTONIOS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 X M 2 □ F Maryland April 20, 28 218-96-4113 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10h County show must be notified at 1 XYes 2 No Directo Baltimore N/A28a-f Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō 21224 USA 629 Oldham Street 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No items 11. Marital Status Examiner 1 X Never Married 2 Married Yes Yes, Give Pages 1 and 2 should be filed within 72 hours after Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ XNo Specify. Specify: White þ 3 Widowed 4 Divorced Year or Dates: 'natural", 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) al Hygiene. Musician Student College 12 years 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 Is marked ot traumatic even Maria Karanikolas Vasilios Nicolaidas ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 629 Oldham Street, Baltimore, Maryland 21224 Vasilios Nicolaidis Father Health a permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 1, 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery Dundlak,Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Connelly Funeral Home Of Dundlak, P.A.
7110 Sollers Point Road, Dundalk, MD. Signature of Furteral Service License 21222 complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a, Part 1. Enter the disease only one cause on each lin shock, or heart failure. Immediate Cause (Final 190 ar **Physician** disease or condition /Medical resulting in death) (or as a consuluence of) Due Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a co Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Completed by No 3 Probably 4 Unknown 1 Tyes within 24 hours after death.

To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner 1 Hospital: 1 Anpatient Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 No 2 ER/Outpatient 3 🗌 DOA မ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 4 🗌 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrár 30. Name and address of person who completed cause of

31. Date filed (Month

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

death (Item 23a) (Type, Print)

Amend #26 & Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 900 PM 2010 Dannon /Medical 4c. County of Death Facility Name (If not institution, give street and number City, Town, or Lo cation of Death **Examiner** anda Town If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday Social Security Number **Funeral** Hours Min. Months Days 1 M X 63 Director 212-46-5792 07 31 46 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State iral", or Items 23a or 28a-f show 1 ☐ Yes 2 🔀 No Director MD Baltimore Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4837 Hawksbury Road 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Black "natural", or Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
Baltimore City th and Mental Hygiene.

7 is marked other than "natur traumatic event, I'm Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Substitute Teacher na <u>School System</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman O'Bannon Zadie Cheatham ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Natalie Haskett-Daughter 4837 Hawksburg Road, Pikesville, Md 21208 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/25/10 Woodlawn, Md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 21. Signatule of Funeral Service License Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedine Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? ρ 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an After this certificate has funeral director, page 2 s autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1X Natural 5 Pending within 24 hours after www...

To the Funeral Director: After the Funeral Director After the Funeral Director After the Funeral Director After Total Director After Total Director After Total Director After Total Director After Total Director After Total Director After Total Director After Total Director After Total Director After Total Director After Total Director After Total Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Director After Di 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29d. Date signed (Month, Day, Year) ture and title of certifie 29b. Sign 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road Randallstown, MD Everett Darr LaFon, MD 31. Date filed (Month, Day, Year) Registrar's Signat State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner BOUTMOIC NUTS | 8. Date of Birth (Month, Day, Year) | Sept 14, 1 9. Birthplace (State or Foreign 6. Sex last birthday **Funeral** 1 M 2 F 1945 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County Injury or other traumatic event, the Medical Evareiner rust be nottilled at 1 Yes 2 No Director Baltimore or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA SSE items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ №6 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No white Specify: þ 'natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other transment." Elementary/Secondary (0-12) College (1-4or 5+) beverage bartender 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Marie Goeb Francis Carmen Salvino 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Raltimore, MD 21221 19a. Informant's Name/Relationship (Type. Print) 807 M. Marlyn Avenue Baltimore, MD Steve Everly/son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signaturi de Funeral de rvice Licensee State Anatomy Board 655 W. Baltimore Street Director enn Baltimore, MD 21201 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant-in the past 12 months? 3 Ectopic pregnancy ō Day Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.0. the 9 Unknown detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 🗌 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Ardising Home 5 Residence 6 Other (Specify) 2 17 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Un atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination/and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manuer stated. the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 2

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Śi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ P :50 Errunyor 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of DALTIMORE Himora 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 5ex 1**X** M 2 □ F Months Hours Director or items 23a or 28a-f show 10a. State Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City Town or Location 10d. Inside City Limits Director atonsville Baltimore 1 🗆 Yes 2 🔀 No 10e, Street and Number 10g. Citizen of What Country' Known as Herbert Parke 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done de fe. QO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. er visor Be 18. 1 nant's Name/Relati**on(**hip *(Type, Print)* 19b. Mailing Address (Streetland Num) 11e, MD 21228 and 2 s f Health ark 20b. Place of Disposition (Name of cemetery, cremator of other 20a. Method of Disposition ō 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) woollawn, 21. Signet, e of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ntracrani disease or condition DAVS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 va Hydrocephalus Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? Diabetes this certificate 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medica the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

• the Funeral Director; After completed filled in by the funer 1 Hatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie ٥ 29c, License number 29d. Date signed (Month, Day, Year) -000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore 31. Date filed (Month, Day, Year) Registrar's Signat

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5,9,11,13,14,15,16a&b,17,18&19a&b, Per ANA BD G901 3/01/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ PM Luis F. Quinones February 2010 Medical 4c. County of Death 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Singi Hospital of Baltimore Baltimore City 9. Birthplace (State or Foreign Year If Unde 8. Date of Birth . Social Security Numbeunk 6 Sex 7. Age (In yrs. last birthday) **Funeral** May 1 Days Hours Min. 1 🕅 M 2 □ F Puerto Rico unk 62 582-98-3229 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a, State Director 1 Yes 2 □ No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21207 USA 4017 Liberty Heights Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by black White Baltimore, Maryland 21215-0036 1 X Yes 2 K No Specify: Puerto Rico 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk National Guard Accountant 1127 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Felicita Gonzales Miguel Quinones Vangas 19a. Informant's Name/Relationship (Type, Print)
Nida Lottier/sister
Sinai Hospital of Baltimore 19b, Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code)
4501 W. Forest Ave Baltimore, MD 21207
-2401 W. Belvedere Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Euneral Service Scensee Ronald S. Wade, Director State and Address of Each Board 655 W. Baltimore Street 21201 Baltimore. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 days disease or condition Seps Medical resulting in death) Due to (or as a consequence of): **Examiner** folminant neogtins 100745 Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit biliary obstaction Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day 1 Yes 2 No 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Chronic Pancreatins perficulted disease, hypertension osteon this Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an Renal corgnome autopsy performed death? 2 X No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury 1. Natural 5 Pending Investigation Accident 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 765-000 February 16, 2010 Vanus Se 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simi Hospital of Baltimore Hamela Damisse, MD 31. Date filed (Month, Day, Year) 32. Registrar's Sanature State MAR 0 1 2010 Registrar

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		Registrar Reg. No. Reg. No.
Physicia	-	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 2106 hrs
[¶] edical Exami	ner	With all Lee Mooring Pedidary 24, 2010
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  342 Bloom Street, Apartment 201  Baltimore
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		Foreign / A
Birector		223-56-4602 1XM 2 F 68 Yrs. Months Days Hours Min. 01 04 1942 Country) VF
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
<b>*</b> .		MD Baltimore 1 20 yes 2 No
Aaryland 28a-f show 1 at once.	ğ	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho	Director	342 Bloom Street, Apt. 201 21217 USA
ith th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
ath w items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
ter de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:
hours afte natural", Examiner	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done  16b. Kind of Business/Industry
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life, DO NOT use retired)
036 ithin ne.	Completed	12th Custodial Assistant Schools
5-0036 iled within 7 Hygiene. I other than the Medica		17 Father's Name (First, Middle, Last)  18 Mother's Name (First, Middle, Maiden Surname)
21215-0036 Uld be filed within 72 Mental Hygiene. marked other than '	a	George Robinson Grace Bailey
	٩	19a Informant Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code)
ages I and 2 shount of Health and Nt. If item 27 is nother traumatic		20a. Method of Disposition    Daughter   37 324 Melvin Ave. Apt A Catonsville MD 21228
F = 5 5		1 Burial 2 Cremation 3 Removal from State crematory or other place
imore Pages I nent of F tant: If i		4 Donation 5 Other Specify: Wood awn lemetery 3.4.10 Wood awn, mD
Baltimo permit. Page Department Important: injury or otl		21. Signature of Funeral Service Licenses 22. Name and Address of Facility reese Funeral Services
and the second	_	23a Part   Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart   Approximate Interval
Physician /Medical		failure. List only one cause on each line.
Examiner		Immediate Cause (Final disease a Atheroscierotic Cardiovascular Disease
		h
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated
ed nsit	Examin	events resulting in death) Last  Due to (or as a consequence of):
executed in and il - transit	g	UNDENDED.
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× 6 th cer ruse	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
Bo e dea ed fo	Phys	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 Unknown 19 U
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should let in by the funeral director, page 2 should	n: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion tendi tor:	atio	1 V Natural 5 Pending 2 Accident Investigation
ViS or At or At Direct in by	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
file or spi	Cert	4 Homicide determined (Specify)
e Hos n 24 h e Fur letely		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the Hos within 24 h To the Fur	Medical	and manner stated
	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  COME
		Mul O O.C.M.E. February 25, 2010
8V		30 Name and address of person who completed cause of death (Item 23a)  Record Alexander MD Accient Medical Examinar 111 Penn Street Raltimore MD 21201
٧		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S Regis	tate trar	
Regis	LUL.	Jouans A - WASA

10-01059 Ray Robinson

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ray Robinson	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2 1 1 5 7 4							
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  2.115 hrs							
Medical Examiner								
	3014 Reisterstown Road Baltimore							
Funeral Director	5. Social Security NumberUnk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min. Mar 7, ±928 South Carolina							
200,000	Usual Residence of Decedent							
y any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
land f show	MD Baltimore 1 K Yes 2 No  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 3014 Reisterstown Road 10f. Zip Code 21215 USA							
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 N							
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215-( be filed ntal Hyg rked off cnt, the								
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene. 27 is marked other than umarite event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address  (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
MD and 2 sh an alth an 27 i	0.C.M.E. 111 Penn Street Baltimore, MD 21201  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State							
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.	1 Burial 2 Cremation 3 Removal from State crematory or other place)							
Itim it. Pag irtment ortant	4 Donation 5 A Other Specify: in State  21 Signature Funeral Service Licensee //// 22. Name and Address of Facility							
Balti permit. Departm Importa	21. Signature Funeral Servic Licensee Ronal S. Wade Steeton State Anatomy Board 655 W. Baltimore Street  Raltimore MD 21201							
Physician	23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.  Approximate Interval Between Onset and							
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):							
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by the attending phy ched for use as the bry Side of Physician Physician/Mc	23b. Was decedent pregnant in the past 12 months?							
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Siou Attendary r death ector: by the	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City							
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the Ho hin 24 I the Fu npletely								
To Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
	O.C.M.E. February 22, 2010							
	30 Name and address of person who completed cause of death (Item 23a)							
Ct-t-	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32 Registrar's Signature							
State Registra	MAD 0 4 0040   //							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 **Physician** February 9:45 Рм Marshall Kalb Reynolds /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Bernie Jnder 1 Year | If Under 24 Hrs Anne Arundel 14 Marley Neck Road
5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Year) Funeral Months Days Hours 1 X M 2 □ F 218-52-3087 60 13 1949 Maryland June_ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examine must be netified at 1 ☐ Yes 2√ No Director Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21060 14 Marley Neck Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: white 1 ☐Yes 2 📉 No Specify \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry unk 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) painter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marshall Kalb Reynolds Sr Edna May Peacher ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 Marley Neck Road Glen Burnie, MD 21060 Gary Reynolds/brother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4K Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee State Anatomy Board 655 W. Baltimore Street i/rector Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate e (Final disease or con ition resulting in death) oph ancer **Physician** /Medical Due to (or as a consequence of) Examiner ren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical use as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy law requires that the death Day for in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a TYRS 2 TNO 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate ospitat or Attending Physician: Thours after death.

neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only on-) Be examiner? Other: 4 \subseteq Nursing Home 1 Yes 2 No 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of D ath 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

adhisht

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lindhitha Maruan Man 305 Hospital Tov.

aruan M-D

29c. License number

D39505

29d. Date signed (Month, Day, Year)

### Physic /Medi Examir **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be inclified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 _ State	Maryland / Depa	artment of Heal		, ,	ene	! Ո	0571.9			
Registrar  1. Decedent's Name (First, Middle, Last)		Timodio or Boo		2. Date of Death	, NO	LU	3. Time of Death			
	oberts, Sr.			Month	Day	Year				
	<u> </u>	4h City Town and age		February	4c. County	010	4:25 A "			
4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Loca	_		,					
2431 Lakeside Drive	7 A - a (Im own load bloth do.)	Frederi	CK Inder 24 Hrs.	9. Date of Birth		eder				
1 X M 2 □ F	7. Age (In yrs. last birthday)  CO Yrs.		ours Min.	8. Date of Birth (Month, Day, Y						
212-58-7568 Usual Residence of Decedent	58 Yrs.			10/24/19	151 Mary		yland			
10a. State 10b. County	1	0d. Inside City Limit								
10a. State 10b. County 10c. City, Town or Location  Maryland Frederick Frederick										
10e. Street and Number		10f. Zip Code		100	. Citizen of W	/hat Cour	otru?			
		·		109			•			
138 Willowdale Dr., Apr			702		U.S.A. Yes or No- 14. Race - American					
Armed Fore		Was Decedent of Hispan If Yes, specify Cuban, Me	exican, Puerto l	Rican, etc.)		k, White,				
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☐ If Yes, Give 3 ☐ Widowed 4 ☒ Divorced Year or Da	e	1 □Yes 2x No Sp	ecify:		Specify.	B1	ack			
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(Specify only highest grade completed)	(Give	kind of work done during DO NOT use retired)	most of workir	king road			_ *			
Elementary/Secondary (0-12) College (1-	4or 5+)	equipment				•	ernment			
17. Father's Name (First, Middle, Last)	Ticavy			(First, Middle, Ma			erimenc			
Bernard Matthew Roberts		131.				-/				
	40L 44-11	ng Address (Street and N		Mabell		State 7	2 Code)			
19a. Informant's Name/Relationship (Type. Print)  Charles W. Roberts Jr./ s					-					
		Lakeside D		Frederic	c. Location -					
20a. Method of Disposition 1 ☐ Burial 2 ဩCremation 3 ☐ Removal from S	tate 200. Place of Dispo	osition (Name of matory or other place)		ate 20	C. Location -	City of To	JWII, State			
4 ☐ Donation 5 ☐ Other (Specify)	All Coun	ty Cremation	1 2/24	/2010   s	Sykesvi	ille,	MD			
21. Signature of Funeral Service Leansee 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762										
23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):  Due to (or as a consequence of):  d.										
in the past 12 months?	ant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the cause of death and the c										
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examiner?  1 Yes 2 No Hospital: 1 Ir	patient 2 ER/Outpatie	Other				er (Speci	wresidenc			
27. Manner of Death 28a. Date of			- 1	28d. Describe how			,,, <u>z</u>			
3 Suicide 6 Could not be determined 28e. Place 6 buildin	er or Run	al Route Number,								
(Check only 2 Medical Examiner; On the ba	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
29b. Signature and title of certifier (Month, Day, Year)  Photoly Clemner, MD  29c. License number  D31761  29d. Date signed (Month, Day, Year)  2/22/2010										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BRIAN M. BECONNOT, MD 581 W. SENEWTH ST. FREDERICK MD 2176										
31. Date filed (Month, Day, Year) 32. B	gistrar's Signature	ball		/			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) SASSI 7:06 P Phyllis I 27 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 3 8 1 Randallstown Northwest Seasons Hospice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days 1 □ M 2 🗷 F 85 216-20-2303 11/28/1924 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐Yes 2 No Woodstock Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21163 9910 Davis Ave 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 □No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Giant Food Meat Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lizzie Sealock Edward Smoot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9910 Davis Ave. Woodstock, Md. 21163. Lee Sassi(Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Alphonsus Date 20c. Location - City or Town, State 20a. Method of Disposition Woodstock, Md. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-5-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel P.A. 21. Signature of Funeral Service License P.O. Box 195 Sykesville, Md. 21784. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ovacian Metastatic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 2 NO 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Md

Director

Funeral

Completed by

Be

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**Funeral** 

Director

within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfort Example of the profiled any injury or other traumatic event, the Wedfort Example of the profiled and injury or other traumatic event, the Wedfort Example of the profiled and injury or other traumatic event.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760, P.0. signed by t Division of Vital Records, page 2 should peen has certificate Physician: funeral director, After this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funera

edical Ex	rooun
ysician/Medi	IF FE 23b. \
by Ph	Part II
ompleted	
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Be

Certification: To

Medical

State Registrar Was decedent pregnant in the past 12 months? 9 🗌 Unknown

25. Was case examiner	referred to medical
examiner	0.77/-
1 L Yes	2 <b>N</b> o
07 11	

1 Matural

3 ☐ Suicide

2 Accident

(Check only one)

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier MS Rycipakse M.D 29c. License number D0057465 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Av. 5-203 > Baltimore, ND. 21209 N.S. Raja Pakse, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 9 per fh g901 3-9-10 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 // 151AM replanta Helene Ida Sank Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BAltimore Washington Arunde Burnie Anne Medical Glen (enter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ju1v 12 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Śex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🏻 F Days Min. Months Hours **Director** Ju₁v 216-01-9667 1919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Maryland Anne Arundel Co. Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8449 Arbutus Road 21122 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. Specify: White 3 K Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry SANK, HELENE (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Cafeteria Manager Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ado1ph Schmidt Augusta Sclifke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 South Old Baltimore Pike, Newark, DE 19702 Mr. James P. Sank / Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Glen Haven Mem. Park 03/03/2010 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave. SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate Due to or as a conse uence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the humal-transf that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1No 1 Impatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and surface and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) February 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRANCIS MD Altimore (crter Henry Washingto Melical 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2 0   0 5 7 5 2										05752		
			Registrar	шсан	2. Date of D				Reg. No. ( U U U J J J Z				
	Physicia	n/	Decedent's Name (First, Middle, Last)     Navnitlal C. Shah						Month Februar		2010	3. Time of Death	
	Medic	al	4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death				unty of Death	19:35 p ^M	
	Examin	er						Park			,	ery Co.	
	F		Washington Adventist  5. Social Security Number   6. Sex.	7. Age (In yrs. las	t birthdav)	If Under		If Under 24 Hrs.	8. Date of Birt	h		nplace (State or Foreign	
	Funeral Director		5. Social Security Number 6. Sex 1218-13-4734	□ F 91		Months	Days	Hours Min.	(Month, Day 04/29/	(Year)	Cou	India	
			Usual Residence of Decedent										
	land sho	to	10a. State 10b. County	, , , , , , , , , , , , , , , , , , , ,	Town or Loc							10d. Inside City Limits	
	Mary 28a- otifie	Director	MD Montgomery	Co. S	ilver							1 🗆 Yes 2 🗖 No	
	h the	alD	10e. Street and Number	D1 000		10f. Zip	0906			J	n of What Cou	untry?	
	th wit	Funeral	14426 Bonifont Park		40.4			- 1- 0-1 1-0 (0	-16 - V N	US			
	deat riter iner		Arm	s Decedent Ever in U.S. led Forces?	13. V	Yas Decedo Yes, speci	ent of Hisp ty Cuban,	anic Origin? (Spe Mexican, Puerto	city Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
36	al", o	d b	If Ye	Yes 2 No es, Give A r or Dates.	1	☐ Yes 2	X No	Specify:		Spe	ecify:	an Indian	
ö	nours latura ical E	Completed by	15. Decedent's Education		16a. Deced					16b. Kind	of Business I		
72	an "n Medi	dm	(Specify only highest grade comp Elementary/Seconday (0-12) Coll	ege (1-4 or 5+)	(Give k	Give kind of work done during most of working fe. DO NOT use retired)				- 1			
7	withii giene er th er th		12	598 (1 4 61 61)	Data	Colle	ction	n Analys	t	Cons	sumer	Reporting	
pu	filed al Hy d oth	Be c	17. Father's Name (First, Middle, Last)				1	8. Mother's Name	e (First, Middle,	Maiden Sur	name)		
yla	Id be Ment arke	욘	Chimanlal M. Shah					Chanda	<u>nben Sh</u>	ah			
Maryland 21215-0036	shou and is m		19a. Informant's Name/Relationship (Type, Print	)		-		d Number or Rura					
<u>~</u>	ind 2 lealth im 27 her ti		Mr. Vijay N. Shah / S									, MD 20906	
OL	ge 1 a		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Remova		ice of Dispos metery, crem	sition (ivam natory or of	her place)		Date		tion - City or		
ţ	t. Pag rtmer rtant rjury		4 Donation 5 Other (Specify)	Atla	ntic							, Maryland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertla Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	701101								Cremation ie, MD 21061	
		$\vdash$	23a. Part 1. Enter the disease, or complications	M01121							i barii.	Approximate	
١.			shock, or heart failure. List only one cause	on each line.	201101 01110							Interval Between Onset and Death	
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9	ate be executed hysician and the burial-transit	dical Examiner	d										
876	tificat ng ph as th	Me	IF FEMALE:								1.		
Box 687	h cer tendi or use	an/	23b. Was decedent pregnant 23c. If ye	es, outcome of pregnan- Live Birth 2 - Fetal	death 3	Ectopic p				23	23d. Date of delivery Month Day Year		
Bo	requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	1 Ves 2 No 4 =	Pregnant at time of de Unknown	eath 5∟	Other (sp	ecify)				WOTH	Day Tour	
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В,	signe signe	d by							1 🗆	Yes 2 🗆	No 3 🗆 Pr	robably 4 Unknown	
ğ	requi	ete							24a. Was	an i	24b, Were aut	topsy findings available	
ec C	e law has ge 2 s	Completed							auto _l perfo	osy rmed2	death?	completion of cause of	
ď	hysician; The lav nis certificate hav I director, page 2	ပ္တိ	25. Was case referred to medical				26 Plac	e of Death (Chec	1 \( \text{Yes}	2 No	1 ∐ Yes	2 🗆 No	
/ita	sicia s cert	To Be	examiner? 1  Yes 2 No	: 1 ☑ Inpatient 2 ☐ E	B/Outnatier	1 3 D DC	Other			dence 6	Other (Spec	ifv)	
of/	g Phy er this eral c				28b. Time of injury		Bc. Injury a work?		28d. Describe h				
no	ath. r: Aft	ical	1 1 Natural 5 Pending 2 Accident Investigation	(Month, Buy, Tear)	injui y	М	1 🗆 Y	es 2 🗆 No					
Division of Vital Records, P.O.	r Atte ter de recto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory	, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			ral Route Number,	
ă	ital o urs af ral Di lled ir												
	Hosp 24 ho Fune sted fi	Medical	(Check 2 Medical Examiner: On the	the basis of examination	and/or invest	tigation, in r	ny opinion	, death occurred a	t the time, date a	cause(s) and manner as stated. e and place, and due to the cause(s) and manner stated.			
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	Julyley Mp 52069 2-26-							- 2010					
	3		30. Name and address of person who complete	ed cause of death (Item :	23a) (Type, F	Print)							
	$\mathcal{I}$		Julie KrivyMP, 103.	13 Georgia	Avei	rue, s	vite	307, Sil	ver Spri	ig N	20 20	902	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire B	8	0						
	Registra	ar	MWZ T A YMM	Dent Black	Bl. A	900 SE	17						

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		artment of H		F	Reg. No.	2010	05753
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last)  Elizobeth  4a. Facility Name (If not institution, give s	treet and number)	Sin	10/100 4b. City, Town, or	COL	2. Date of Dea	Day 2	Year Ounty of Death	3. Time of Death
Į.	Funeral	lei	The Johns Hopkins Ho  5. Social Security Number 219-49-3402  6. Sex		ast <i>birthd</i> ay) Yrs.	Baltimore If Under 1 Year Months Days	City If Under 24 H	n. (Month, Day	, Year)	N/A  9. Birthp Count	place (State or Foreign
	Director -f show	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo			June 20	19		ry1and  Od. Inside City Limits  1 □ Yes 2X No
	th with the 23a or 28a st be notifi	al Director	10e. Street and Number  1532 Tieman Drive		ren bu	10f. Zip-Code	21061		Ü	in of What Coun	•
130	urs after deal Il", or items xaminer mu	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ☑ No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, e	
1215-0036	and 2 should be filed within 72 hours after death with the Maryland salth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show er traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired, tudent	during most of w	orking		d of Business/Ind	dustry
land 2	ild be filed v lental Hygie rked other t ic event, th	To Be Co	6 17. Father's Name (First, Middle, Last) Timothy Smallwoo	od			18. Mother's N	ame (First, Middle, n Thoma	Maiden S		
, Mary	ss 1 and 2 shou of Health and M item 27 is mar other traumat		19a. Informant's Name/Relationship (Type Mrs. Lynn Smallwoo	od / Mother	1532	Tieman D	and Number or	Rural Route Nurnbe 1en Burni	.e, M	D 2106	1
Daltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 A Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	emoval from State Ced	emetery, cren lar Hi	sition (Name of natory or other place  11 Cemete  Name and Addres	ry 3/0	3/2010 ingleton	Brool		rk, MD
1	Physician /Medical Examiner	į	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	M011 Deticors that caused the death e cause on each line.  Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of	Do not ento		g, such as card		rest,	en Burn	ie, MD 2106. Approximate Interval Between Onset and Death
, , oo,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, Learning to human additional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director is a second to the funeral director of the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral director is a second to the funeral direct	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1  Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy	1		23	d. Date of delive Month	ery Day Year
COLOS, F.	equires that en signed by ould be deta	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		_	he cause of death?
מו חמני	The law recate has been, page 2 sh	Completed							med?	prior to co	psy findings available mpletion of cause of 2 $\square$ No
5	r this certificeral director	n: To Be	27. Manner of Death	28a. Date of Injury	ER/Outpatient	28c. Injury	er: 4 □ Nursing	eath <i>(Check only on</i> Home 5  Resident Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particles Particl	ence 6		)
DISIN	or Attending after death. Director: Afte I in by the fun	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined .	(Month, Day Year)  28e. Place of injury - At hor building, etc. (Specify,	Injury me, farm, stre )		? ∕es 2 □ No	28f. Location (S City or Town		Number or Rura	al Route Number,
	ie Hospital n 24 hours le Funeral	edical C	29a. Certifier 1. CertifyIng Phys (check only one) 2 Medical Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred at the tim restigation, in my of	ne, date and pla pinion, death oc	ce, and due to the c curred at the time,	cause(s) a date and p	nd manner as si place, and due to	tated. o the cause(s)
	Vithi Com	ž	29b. Signature and title of certifier	nox MD		29c. License	number		29d. Date s	signed (Month, L	27, 2010
	Sta	te.	30. Name and address of person who co	MOX MO 32. Registrar's Signatu	ure		600	North Wo	lfe St,	Baltimor	e, MD, 21287
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink, Assure All Copies Are Legible. amend #18,20a-c&22 Per FH G901 3/19/2010 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Neme (First, Middle, Lest) Dey Month Year **Physician** 11:03 AM Jesse Stern 2010 tebruary 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street end number) Examiner Ann Arundel Jessu Correctional Institute Jesser If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 112M 2□ F 219-88-8415 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2X No Jessup Director Anne Arundel MD 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20794 USA P.O. Box 534 by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) maintenance Ravens stadium 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) unk Be Jesse Stern Marian မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 923 McHenry Street Baltimore, MD 21203 Tynika Stern/daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State 3/19/2010 **Greenmount Crematory** Balto. Md 4 □ Donation 5 ₩Other (Specify) in state 21. Signature of Euneral Service Licensee
Ronald S. Wade, Director
Per DVR

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 655 W. Baltimore Street Funeral Service P.A. 1701 McCulloh Street Approximate Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) Examiner cver Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 1 🗆 Yes 3 Probably 4 Unknown ģ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed

**Physician** /Medical Examiner

physician end s the buriel-transit

for use as

After this certificate has been signed by the a funeral director, page 2 should be deteched

Be

Certification: To

Medical

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

or A

To the Hospital or within 24 hours a To the Funeral D

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

death with the Maryland

be filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

altimore, Maryland 21215-0020

Show

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinal must be notified at

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25.	was case examiner?		to mean	caı
	1 Yes			
27	Monnor of	Dogth		

28a. Date of Injury (Month, Dey Year) 5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a.	Certifier
	(Check on
	one)

31. Date filed (Mor

1 Natural 2 ☐ Accident

3 
Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

unbig Gatwar um

State Registrar Registrár's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 **Physician** 9:05 January 31 A M James Rhodes Sidell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 17809 Meeting House Road Sandy Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 6, 1946 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Country) Maryland Days 1**)** M 2 □ F 63 213-44**-**6475 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Montgomery Sandy Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20860 17809 Meeting House Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 maintenance director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Rhodes Sidell Laura Jane Lawson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda J. Sidell/spouse 17809 Meeting House Road Sandy Spring, MD 20860 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Services licensee de State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Party. Enter the diseast, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER OlON **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Paneral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 2 To the

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29c. License number

111

29d. Date signed (Month, Day, Year)

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3418

wood Srite

√ 32. Registrar's Signature

			For State Registrar		State of	Maryland		artment of H		and Mental	Hygien Reg. N	2010	05756	)
	Physici		1. Decedent's Name	(First, Middle, La	Sc.	hwe	, 1+	700		2. Date of Month	Peath	ay Zar	3. Time of Death	_
-	/Medio Examin		4a. Facility Name (If	not institution, giv	e street and numb	er)		4b. City, Town, o			4	c. County of Dea		-
-	E		Seasons  5. Social Security No	Hospice/		t Hosp		Kanda If Under 1 Year	11stov		f Birth		thplace (State or Foreign	7
	Funeral Director		219-26-8		<b>M</b> 2□F	72	Yrs.	Months Days	Hours	Min. (Mont. Sept	Day Yea	r) C	o <i>untry)</i> ryland	
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
	a-f sh	ctor	MD	Baltimor	e		Pikes	ville					1 □Yes 2√2 No	
	ith the	Director	10e. Street and Num		. "0			10f. Zip Code	1000		10g. (	Citizen of What C	ountry?	
	ns 23e	Funeral	14 Stone	ehedge Ci	rcle #3	ent Ever in U.S	S. 13.		1208 Hispanic Orio	gin? (Specify Yes	or No-	USA 14. Race - Am	erican Indian.	_
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be muffled at or other traumatic event, the Madical Examiner must be muffled at	þ		ed 2 Married	Armed Force 1 □Yes 2 If Yes, Give Year or Date	es? <b>X</b> ]No		If Yes, specify Cub 1 □ Yes 2 🔯 No		gin? (Specify Yes on the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the secon	.)	Black, Whit		
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Maryland	hould I id Men marke matic	2	19a. Informant's Na	l Schweit			10b Maili	ng Address (Stroot		lie Berth		<u> </u>	Zin Codo)	
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Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disp 1 ☐ Burial 2 ☐ 4 🕅 Donation	oosition Cremation 3  5 Other (Special	Removal from St	ate	lace of Dispo emetery, crea	osition (Name of matory or other pla		Date		Location - City or		
Balt	permit. Pa Departmer Important any Injury once.		21. Signature of Eur	neral Service Lices	Wade, D	rector		2. Name and Addre tate Anat altimore,	omy B	oard 655 21201	W. Ba	ltimore	Street	
	Physician /Medical Examiner		Immediate Cause ( disease or condition resulting in death)	rt failure. List only Final n	a.	sed the death life.	solo	ter the mode of dyi	~	cardiac or respirat		an O	Approximate Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	cal Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) L	mediate rlying injury	C	as a consequ								
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.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		th 2 ☐ Fetal nt at time of d	Ideath 3	☐ Ectopic pregnan ☐ Other (specify) _	су		min Million de	23d. Date of do Month	elivery Day Year	
rds, P.	w requires that s been signed b should be deta	by	Part II. Other signif	icant conditions	contributing to dea	th but not resu	ulting in the u	inderlying cause gi	ven in Part I.		Did tobacc		to the cause of death?  Probably 4 Onknown	1
Il Records,		Completed							,	24a.	Was an autopsy performed //es 2	prior to death?		9
Vital	siclan certifi rector,	Be	25. Was case referrexaminer?		Hospital:			Oti	hor.	of Death (Check		Neo	1010	
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sior	tending Feath.  or: After the funer	catio	1 Natural 2 Accident	5 ☐ Pending investigatio 6 ☐ Could not be	n			M 1 🗆	Yes 2	No				
Division	To the Hospltal or Attendl within 24 hours after death. To the Funeral Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place o building			reet, factory, office	·	City	or Town, St	ate)	Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one)	2 Medical Exa	hysician: To the base miner: On the base and manne	sis of examina	wledge, dea ition and/or i	nvestigation, in my	opinion, dea	nd place, and due tath occurred at the	time, date	and place, and du	ue to the cause(s)	
	vit To co⊓	2	29b. Signature and	title of certifier	08/	n	Mr	29c. Licen	se number	72		Date signed (Mor		
			(mrs.		CBMI	2	285	- Sm.D	A	RHLD	BAL	Timor	21209	7
	Sta Registi		31. Date filed (Mon.	AR 0 1 20	10 Det	gistrar's Signa	1. 19	alla						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19a, perFH, G901, 3/8/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month )imitri 00:46 M illiams -e 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Center Baltimore University Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X X** M 2 □ F Months Days Hours Min. Month Day Year 2-8-1968 Country) 42 218-29-1806 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1X☐ Yes 2 ☐ No Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1605 Homestead Street 21218 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled 12th grade Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Lee Williams <u> Annie Rav McElveen</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Annie Ray Williams-Mithe 2639 Cecil Avenue Balto, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State King Memorial Pk 2-27-2010 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service March East F/H 22. Name and Address of Facility 1101E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ranja Medical Due to for as a consequence of: Examiner tracrania Securetially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease, endocard Hospital or Attending Physician: The law requires 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rosthetic valves on council autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ၉ 1 Natient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the and title of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ۵ D0065118 Feb. 22, 2010 ame Woodes MD Stancie C. Khodus, MD, 22 S. Greene Street Battimore, MD 21201 6 1 31. Date filed (Mont) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . Month Day 25 200 Februa 1:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Ye Year) 1930 1**X** M 2 □ F Days Hours Director 218-26-9166 79 Nov. Ohio Usual Residence of Decedent 23a or 28a-f show 10a State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3900 Pennington Avenue 21226 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1951- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black. White, etc Š 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Completed 3 Widowed 4 Divorced Specify: 1959 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Lathe Operator Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Troy Thomas Williford, Agnes Betty Russ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Williford / Brother 310 Holy Cross Rd. Brooklyn, MD 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 03/01/2010 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumonic Medical Due to (or as a consequence of) **Examiner** month Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 ending phys 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ☐ Yes 2 🔀 No 1 ☐ Yes 2 🖾 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Yes 2 🛛 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural inlury work? 5 Pending 24 hours after death. Funeral Director; A within 24 hours after death

To the Funeral Director: A
completed filled in by the f 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sta

Registrar

fimere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ рМ Howard Parrish Walter F<u>eb</u> 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove Carroll House Westminster Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months Days Country) Maryland 1 XM 2 🗌 Hours Min. (Month, Day, 89 Dec. **Director** 218-07-5198 Usual Residence of Decedent or 28a-f show 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Reisterstown 1 🗆 Yes 2 🖄 No Marylan@ Carroll 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 U.S.A. 3693 Clydesdale Road Way within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 1 Yes 2 TyNo Specify. ould be filed within 72 hours aft id Mental Hygiene. marked other than "natural", If Yes, Give Year or Dates 2 - 1945 If Yes. Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Truck College (1-4 or 5+) Elementary/Seconday (0-12) Warehouse Worker/Driver Paint Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Wagner Benjamin Franklin Walter permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 \$693 Clydesdale Road Way, Reisterstown, Evelyn M. Walter - wife March Date , 2010 Coc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 15☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) Finksburg, MD. Evergreen Mem. Gardens 22. Name and Address of Facility Eckhardt Funeral Chapel P. A 21. Signature of Funeral Service Licensee Ech Houth 3296 Charmil Dr. Manchester, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on ear line Immediate Cause (Final Pnysician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending phases the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed within 24 hours after death. To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autope performed : 2 No mentio 2 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 X No House မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cher (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury work? 1 \( \text{Yes} \quad 2 \( \text{No} \) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. in by 1 determined City or Town, State) To the Hospital filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title ertifie 29c. License number 29d. Date signed (Month, Day, Year) 0036112 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwoods TRail Hampstead, Md D.A. Rocha 4231 31. Date filed (Month 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Physician/ Ellen Watts 2010 Marie 7:15p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛣 Months Min. 217-24-1919 Days Hours Director 83 nà 04 26 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-fs other traumatic event, the Medical Examiner must be notified 1 Yes 2 No Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 U.S.A. 6209 Winner Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) School System 12th grade Teacher 4yrs+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Hall Warner Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6209 Winner Ave, Baltimore, Md 21215 Patricia Djokoto-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Lukes 2/25/10 Reisterstown, Sign Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Masch which was the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Baltimore, 21215 Approximate Interval Between Onset and Death Imprediate Cause (Final Physician/ BREAST CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 L Feta Cal Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 X No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and atle of 29c, License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

FEBRUARY

MARIE

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

r's Signature

CRNP

32. Registr

2010 ▶

JACKIE JONES,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LARY 22 6:13P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death t Tawsan Medical Center Saint Joseph 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** -20.465 Months Days Hours Min. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Yes 2 No Himore 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a SA items ; within 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 🚺 No If Yes. Give Specify marked other than "natural", 3 Widowed 4 □ Divorced Completed Year or Dates. injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working fe. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Be should be filed 17. Father's Name (First, Middle, Last) 18. Mether's Name ( rst, Middle, Maide Richard Johnson permit. Page 1 and 2 shot.
Department of Health and
Important: If item 27 is m
any injury or other transm 19a. Informant's Name/Relationship (Type, Print) Dans Her 19b. Mailing Address (Street and Number nthia W. 10.MD21108 Nethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 0 110/55 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) UROSEPSIS Medical Due to (or as a consequence of): **Examiner EDAYS** TRACT INFECTION URINARY Sequentially list conditions, cause (Disease or iinjury that initiated events Due to for as a consequence of Examir attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Tyes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑ opatient 2 ☐ ER/Outpatient 3 ☐ DOA Marmer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗖 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 22,2010 D63844 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 7601 FINAGROS D. 31. Date filed (Month, Day, Year) ₱32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death A 2. Date of Death Physician ILLIAMS **Month** Year 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE DSPI If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign County) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F 14-40-3578 Usual Residence of Decedent Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the My clical Experimer must be notified an once. 1 res 2 No Director ltimore 10g. Citizen of What Country? 21205 Funeral Was Decedent Ev.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) IVat 17. Father Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Doensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final GI Ble **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by acro 1 ☐ Yes 2 ☐ No 3 ☐ Probably ▲ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy Division of Vital 2 No 1 □Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

501

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20

US 4717

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3. Time of Death Physician/ Month Wilbur W. Wittler 2010 5:30 F<u>ebruary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Co. Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 212-03-1662 94 29,1915 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f shov Ex-miner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Directo Baltimore Co. 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 United States 7433 Berkshire Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give ↓ ₩ Year or Dates. Š Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. WWII "natural", Specify: 3 TWidowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumasts. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police officer Law Enforcement 6 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Hall Milton Wittler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7433 Berkshire Road Baltimore, Maryland 21224 Mrs. Helen L. Volgt (Daughter) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State ematory or other place) Gardons of Faith Cem. 2/26/2010 Baltimore, Maryland 4 ☐ Donation ≠5 ☐ Other (Specify) 2. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 21. Si nature Funeral Service Lic 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ZHEIMER'S Onset and Death Pnysician/ DISEASE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 the SS IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď VASCULAL PERIPHERAL DISEASE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? ESSENTIAL 24a. Was an Hospital or Attending Physician: The law After this certificate has funeral director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 1 Hursing Home 5 Residence 6 Other (Specify) 2 **1** No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending in 24 hours after death.

he Funeral Director: After pleted filled in by the fun 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only one 29b. Signature and title of certific 29c, License number 29d. Date signed (Month, Day, Year, D0067788 MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print EENA RAO KODALI 31. Date filed (Month, Day, Year) MAR 0 1 201

Registrar DHMH 17 Rev 7/2009

State

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Walker Charles William 2010 3:30PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Country Companions <u>Taneytown</u> Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months (Month, Day, Year Country) Director 59 215-56-5644 July Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No MD Carroll Taneytown 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4015 Kump Station Road 21787 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō 1 Never Married 2 Married δ Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 ☐ Widowed 4 👿 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self Employed Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ be Charles Gold Walker Lillian Jeanette Kneller permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward C.K. Walker Brother Old Quarter Road, Upperco, MD 21155 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Emory Church Cemetery 2/26/10 Upperco, MD permit. Signature of Funeral Service 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No detached the Unknown g Unknown P.O. s been signed by the should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performe death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Spec this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 24 hours after death Funeral Director: A 1 Yes 2 No Accident Investigation the within 24 hours after der

To the Funeral Director

completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatare and title of certifie 29c. License number

State
Registrar

DHMH 17 Rev 7/2009

nd address of person who completed cause

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michelle Woodward	1.	- For State	Sta	ite of Maryla		epartment o <i>Certificate o</i>		Mental H		eg. No. 2011	05765
Physician/ Medical Examine		i. Decedent's Name		,Last) Michelle		Woodward			2. Date of Dea Month February	Day Year	3. Time of Death 2254 hrs
	4	ta. Facility Name (it	f not institution				4b. City, Town, or L Glen Burnie	ocation of Death		4c. County of De	
Funeral Director	5	5. Social Security N	lumber 6	5. Sex 1 M 2 XF		yrs. last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min			Birthplace (State or reign Country)
any	-	Jsual Residence of 10a. State	Decedent 10b. County		10c.	City, Town or Local	tion				10d. Inside City Limits
rland f show		PA		caster				Lancas			1 Yes 2 No
the Maryland a or 28s-f sh tifted at once	1	10e. Street end Nur 47 B S		rg Pike			10f. Zip Code	02	1	Og. Citizen of What C	
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		11. Marital Status 1 Never Marrie	ed 2XXX Mar	12. Was De Armed F	orces?		as Decedent of Hisp es, specify Cuban,	anic Origin? ( S			nerican Indian, Black,
ural", o	ì	3 Widowed  15. Decedent's Ed		rced If Yes, Give Ye or Dates: fy only highest gra	44	1 1 16a. Deceder	Yes 2 No		work done	Specify: 16b. Kind of Busine	White ss/Industry
5-0036 ed within 72 hour tygene. other than "natt the Medical Exa	-	Elementary/Seco	ndary (0-12)		1-4 or 5+)	during m	nost of working life. I emaker			Own Hom	
215-0 be filed w mtal Hygie rked other ent, the M		17. Father's Name (	First, Middle, L	ast)						Maiden Surname)	
MD 21215-0036 to 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than aumatic event, the Medical To Be Comple		Kenne 19a. Informant's Na	eth E. me/Relationshi			19b. Mailin	g Address (Street		Henderso	DII nber, City or Town, St	ate, Zip Code)
, MD and 2 sh ealth an em 27 i	2	Michael 20a. Method of Disp		rd (Husb	and)	47 20b. Place of Dispos			Lancas	ster, PA	
MOFE	1	1 X Burial 2	Cremation		rom State	crematory or ot	herplace) t. of Jes	us Cem	3/1/20		
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr		4 Donation 5	neral Service L	Ticensee		22. [	Name and Address	of Facility Funera	1 Home	of Dundalk Maryland	
Physician /M-diI	2	23a. Part I. Enter the failure. List only			aused the o	death. Do not enter t					Approximate Interval Between Onset and Death
Examiner		Immediate Cause (F or condition resultin		a. Fentar  Due to (or as a		ntoxication nce of):	n				Deatil
- L	S in	Sequentially list cor if any, leading to im		b Due to (or as a	a consequer	nce of):					
ted Insit Examiner	(	cause. Enter Under Disease or injury the events resulting in o	rlying Cause nat initiated	Due to (or as a	consequer	nce of):					
(0, e be executed ysician and burial - transit	F	X UNPENDED		d.							
60, ate be e physicial re burial		F FEMALE:		23c. If yes,	23a,27 outcome of	,28a-f,pe	er ME g901	l TT		23d. Date of deliv	very
Sox 6876( leath certificate e attending phys for use as the b	23	3b. Was decedent past 12 months:  1 Yes 2 V N	?	4 Pregi	nant at time	of dooth	etal death 3 ther (Specify)	Ectopic pregna	ancy	Month	Day Year
P.O. Bc intar the des med by the a detached ft		Part II. Other signif	ficant condition	ens contributing t	o death but	not resulting in the i	underlying cause giv	ven in Part I.			to the cause of death?
ds, Pequires ten sign build be of									24a. Was	an 24b. Were	robably 4 Unknown autopsy findings available
Records, The law require ficate has been signage 2 should b. Completed									1 Yes	rmed? death	
Vital ysician: his certif director	2	25. Was case referr examiner? 1 ✓ Yes 2	ed to medical	Hospital: 1	Inpatient :	2 🗸 ER/Outpatient		of Death (Check Other   Nursir		Residence 6 0	her:
ing Phy After th funeral	12	27. Manner of Death	1		of Injury n, Day,Year)	28b. Time of			_	how injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the buriledical Certification: To Be Completed by Physician/Med		2 Accident 3 Suicide	Fendir Investi	igation Fd 2		Fd 10:1 At home, farm, stre	et, factory, office bu				Rural Route Number, City dlake Ct
To the Hospit within 24 hour within 124 hour completely fill ledical Ce	2 (	Ondon only		vsician: To the be	st of my kno of examinat	owledge, death occu	rred at the time, date	e and place, and	due to the caus	nrnie, MD e(s) and manner as s and place, and due to	
	2	9b. Signature and	title of certifier	and manner	nateu.		29c. License			29d. Date signed (	
	3	30. Name and addre	ess of person w	who completed care	se of death	(Item 23a)	O.C.M	I.E.		February 23, 2	.010
		Donna M. Vi	incenti, MD	Assistant I	Medical E	Examiner 11	Penn Street,	Baltimore, M	ID 21201		
State Registra	9 3 r	31. Date filed (Monti	"MAR"O	1 2010 ^{32. R}	egistar's Si		back				

1-1. D

Be Completed by Funeral Director

으

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

29b. Signature and title of pertifier

Saoldev-S.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. Sachelev MD 126 A, E Fligh St

31. Date filed (Month, Day, Year)

NAR 0 1 2010

September 1 2010

Application of the person who completed cause of death (Item 23a) (Type, Print)

S. S. Sachelev MD 126 A, E Fligh St

31. Date filed (Month, Day, Year)

**Physician** /Medical

Examiner

**Funeral** 

Director

Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rediffied at once. once.

Physician /Medical **Examiner** 

For State Registrar							Ensure A		_	_	ble.	
i region di		State of Ma	ryland /		artment <i>rtificate</i>			Menta	al Hygie Reg.	0.0	In	05768
1. Decedent's Name (First	, Middle, Last)								e of Death			3. Time of Death
Janine Re	nee Wvr	nholds						Feb		Day 22, 2	Year 010	12:35 PM M
4a. Facility Name (If not in					4b. City,	Town, or	Location of Deat			4c. County		12.00 111
Abby Mano	r Asst	Living			El	Lkto	n			C	ecil	
5. Social Security Number			(In yrs. last	birthday)	If Under	1 Year	If Under 24 Hrs	8. Dat	e of Birth onth, Day, Ye		9. Birthi	place (State or Foreign
213-38-5036	1 🗆	IM 2 <b>∏</b> F	90	Yrs.	Months	Days	Hours Min.	Oct	20,	1919	Nethe	rlands
Usual Residence of Deced	lent						,			1		
	County		10c. City, To								1	0d. Inside City Limits
MD	Cecil			E1kt	on							1 □Yes 2 <b>X</b> No
10e. Street and Number One Coloni	al Man	or Court			10f. Zip	Code	21921		10g.	Citizen of V	What Cour	ntry?
11. Marital Status		12. Was Decedent E	ver in U.S.	13. V	Nas Deced	ent of H	spanic Origin? (8	Specify Ye	s or No-	14. Rac	e - Ameri	can Indian,
1 Never Married 2		Armed Forces? 1 ☐ Yes 2 🛣 N		1	fYes, spec	ify Cuba	spanic Origin? (5 n, Mexican, Puer	rto Rican,	etc.)		ck, White,	
3 ☐ Widowed 4 🎇 Di		If Yes, Give Year or Dates:		1	I∐Yes 2	No.	Specify:			Specify	whi	ite
15. De	ecedent's Educ	cation	10	6a. Deced	dent's Usua	Occup	ation		161	. Kind of B	usiness/In	dustry
(Specify only	/ highest grade	completed)		(Give life. L	kind of wor. DO NOT us	k done d e retired	luring most of wo )	orking				,
Elementary/Secondary (	0-12)	College (1-4or 5- 5+	F)				rian			edi	ucati	ion
17. Father's Name (First, I	Middle, Last)						18. Mother's Na	me (First	Middle, Mair			
Jans Wyn							Trynti				,	
						(5)						
19a. Informant's Name/Re Renee Boy			1				and Number or R Venue El			ity or 10 wn, 21921	State, Zij	Code)
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cren 4 【 Donation 5 ☐ O	nation 3 🗆 🖪	emoval from State	20b. Place ceme	of Dispos etery, cren	sition (Nam natory or ot	ne of ther plac	e)	Date	200	. Location -	· City or To	own, State
21. Signature of Funeral S		e Jada Dira	otor	22	. Name and	d Addres	ss of Facility omy Boar	.4 65	5 T.J D	01+1m	0.780	Ttroot
• Rona	<u> </u>	ade, bir		Ba	iltimo	re,	MD 212	01	J W • D	altim	ore i	otieet
23a. Part 1. Enter the dise shock, or heart failur	ase, or compli	cations that caused	the death. D	o not ente	er the mode	e of dyin	g, such as cardia	ac or respi	ratory arrest,			Approximate Interval Between
Immediate Cause (Final	o. List offiny off	7	) om a	tio								Onset and Death
disease or condition resulting in death)	a a	Due to (or as a	CONSECUENCE	1 44 m								years
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if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	` ⊀											
that initiated events resulting in death) Last	С	Due to (or as a consequence of);										
,		Due to (or as a	. ovnsequent	70 VI).								
	d											
IF FEMALE:										T		
23b. Was decedent pregn	anı	3c. If yes, outcome of 1 ☐ Live birth			Ectopic pr	regnance	,				te of deliv	
1   Yes 2   No. 4   Pregnant at time of death 5   Other (specify)   World					Day Year							
9 ☐ Unknown		9 ☐ Unknown										
Part II. Other significant o	onditions con	tributing to death bu	t not resulting	g in the ur	nderlying ca	ause give	en in Part I.	23	e. Did tobac	co use con	tribute to t	he cause of death?
	Tensio	n							1 ☐ Yes	2 No	3☐ Pro	bably 4 ☐ Unknown
tupes	ama's:							-	lo \Ma	0.41	More	anny finalines available
Hyper	NIOSIS.				<del></del> -			.   24	la. Was an autopsy	12 24b.	prior to co	opsy findings available ompletion of cause of
Hyper Osteof								1[	performed ⊒Yes 2 🖫		death? 1 ☐ Yes	2 □No
Hyper Osteof												
25. Was case referred to r	_						26. Place of De	eath (Chec	k only one)			
	_	lospital: 1	nt 2□ER/	'Outpatien	nt 3 🗆 DO	A Othe				e 6 □Oth	ner (Speci	ífy)
25. Was case referred to rexaminer? 1 ☐ Yes 2 Mo 27. Manner of Death	Н	1 🗀 inpatie		b. Time of		8c. Injur	er: 4 Nursing	Home 5				ify)
25. Was case referred to rexaminer? 1 □ Yes 2 ▼No 27. Manner of Death	_	ospital: 1				8c. Injur Work	er: 4 Nursing	Home 5	Residenc			ify)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0023322

Elkan MD 21921.

29d. Date signed (Month, Day, Year)

2.22.2010.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** rman /Medical 4c. County of Death 4b. City, Town, or Location of Death, acility Name (If not institution, give street and number) Examiner land TIMOSE If Under 24 Hrs. Hours Min. Age (In yrt. last birthday, Date of Birth Birthplace (State or Foreign Oountry) 5. Social Security Number Year **Funeral** Months Days 1 M 2 □ F 213-62-430 5 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Funeral Director FINDERS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21201 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No a q Year or Dates: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Rchani 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Plice Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 BBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) and Address of 21. Signature of Funeral Solvice Licensee Name 23a. Part1. Enter the disease, or complications that sal shock, or heart failure. List only one cause on ear Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) compensated **Physician** /Medical Due to (or as a consequence of): Examiner ncreati if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an 2 No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check onl one Be Other: 1: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ² 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Death Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 4 Homicide 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Adams Kenneth Η. 9,2010 1459 Medical Fobruar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, Aug. 25, 1 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☑ M 2 ☐ F Director 79 577-34-9196 Wash Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director PG 1 X Yes 2 No MD Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 2323 Wyngate Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 🙀 Married þ 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Adams Maudella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 Suit Wyngate Road Land Md 20746 Althea Adams/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/12/10 1 X Burial 2 Cremation 3 Removal from State Veterans Cemetery Cheltenham, Md. 4 Donation 5 Other (Specify) Md. 21. Sign vul of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Part 1. Shiter the disease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) or as a consequence of Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No the 9 Unknown Division of Vital Records, P.O. ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 200 Other: ၉ 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this. 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1/Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Nurse Fractioner: To the best of my in cylicidy could be counted at the time. Sets and place and counted by a dimensional stated. orty one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Day, Year State FEB 1 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #3 PSTATE of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February 8, 2010 Physician 11:03 🏴 Carl James Argerie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sandy Spring Montgomery Friends Nursing Home 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York Social Security Number 7. Age (In yrs. last birthday **Funeral** . 1911 Days Months Hours Min. 1 3 M 2 □ F 98 Yrs 577-05-5192 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 20906 3520 Weller Road USA r than "natural", or Items 23a the Medical Examiner must t Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No. WWII If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ð 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Buyer Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore Argerie Antonino Arenas မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3520 Weller Road, Silver Spring, MD 20906 Mary R. Kerere/Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗓 Burial 2☐Cremation 3 ☐Removal from State Feb. Gate of Heaven Cemetery 2010 5 ☐ Other (Spec Silver Spring, Maryland 4 ☐ Donation Name and Address of Eacility rancis J. Collins Funeral Home Inc. OO University Blvd. W., Silver Spring, MD 2090 21. Si nature of Funeral Service Licen 22 Name and Acoustic Collins Ton. Francis J. Collins Ton. 500 University Blvd. W., 23a/ Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Inanition 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier



30 Name and address of person with completed cause of death (Item 23a) (Type Print) Drive, Olney, MD 20832

🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D35045

29d. Date signed (Month, Day, Year)

February 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05/ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:40p Harry Lee Armiger Februar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Westminster 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year)
July 26, 1 🛛 M 2 🗆 F Months Days Hours 68 July 1941 Maryland <u> 220–36–7701</u> Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3615 Turkeyfoot Road 21158 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give 1 Yes 2 No Specify. 3 - Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Grocery Store Meat Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Armiger Harry LeRoy Dorthea Stuart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Nikole Gonder/daughter 3615 Turkeyfoot Road Westminster, Maryland 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 😾 Cremation 3 🗌 Removal from State Donation 5 Other (Specify) Final Journey Crematory 2/16/2010 Woodbine, Maryland ure of Funeral Service License Going Homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 MD 21029 thomas 23a. Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line enter the hode of dying such as cardiac or respiratory arrest, death. Do p Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nce of)

Physician/ Medical Examiner

Physician/

Medical

Director

Completed by Funeral

Be

2

**Examiner** 

**Funeral** 

Director

be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

f Health item 27

permit. Page 1 a Department of H Important: If ite any injury or ot

other

Page 1 and 2 should

Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

r .	Due to (or as a consequence of):
b. •	
0.5	Due to (or as a consequence of)
С.	
0.	Due to (or as a consequence of)
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

Physician/Medical

Completed by

Be

မ

Certificate:

Medical

29a. Certifier

11	yes, outcome of pregnancy
1	Live Birth 2 Fetal de
4	Pregnant at time of deatl
q	Unknown

eath h	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Month

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2	
24a. Was an autopsy	2
performed?	

No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available

. Was case referred to medical	
examiner? 1  Yes 2 No	Hospital:

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice ER/Outpatient 3 DOA

death?	2 No	e oī

1 🗆 163	1110
27. Manner of Death	
1 Natural	5 Pending
2 Accident	Investiga
3 Suicide	6 Could no
4 Illowipida	determin

28a. Date of injury (Month, Day, Year) ation ot be

. Date of injury (Month, Day, Year)	28b. Time of injury		28c. Injury at work?	
		M	1 Tes	2
Place of Injury - At he building, etc. (Specify		t, facto	ry, office	

28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)		Medical Exan Certifying Nu
29b. Signature	and title	of certifie

Name and address of person wh

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the best of my knowledge, death oc

32. B

curred at the	time,	date	and	piac	e
29c. License	numb	3	0	7	1

LIESTMIUSIE IND 21157

, and due to	the cause(s) and manner as stated.
)	29d. Date signed (Month, Day, Year)

341

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversid inversignment.

Division of Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 7/2009

Couter Street

ompleted cause of death (Item 23a) (Type, Print)

gistrar's Signature

RELAKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Buskey George Gaylon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Allegany County Nursing Home Cumberland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 🗆 M 2 🗆 F Hours (Month, Day, Year) Feb 15. Director MD 217-18**-**4213 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural". or item. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD Allegany Cumberland 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13807 Bluebird Lane 21502 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ 📉o WW II Specify: 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CSX Railroad pipefitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George F. Buskey Daisy (Stump) Buskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13807 Bluebird Lane MD 21502 wife Cumberland Dorothy Buskey 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 2/24/2010 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a conveyuence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not res**∮**lting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Discorse 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.1 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 29d. Pate signed (Month, Day, Year) 29c. License number 0003328-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician soone 2037 onna 010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GEORGES HOSPITAL Hei ince GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) Date of Birth (Month, Day, 1 □ M 2 😿 F Months Days Hours Min. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. ет 27 Is marked other than "natural", or ite 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VURSE vare TH 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 Department of Heal Important; If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lensee em .Z0002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician day Au-nya disease or condition resulting in death) /Medical Due to (or consequence of Examiner Sequentially list conditions, if any cause conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 힏 in the past 12 months? 1 ☐ Yes 2 🛂No Month Year Day 5 Other (specify) 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has birector, page 2 st 24a. Was an autopsy perforn 2 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Unpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Aff
bletely filled in by the fur 2 Accident 1 ☐ Yes 2 🗆 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760.

P.0.

Records,

Division of Vital

State Registrar

completely

within 2 To the

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) FEB 1 6 2010

ames

29b. Signature and file of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u>Glo</u>ria Denise Bynum 02 2010 10:44 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **Director** 45 245-27-4957 / 1964 NC Usual Residence of Decedent 28a-f shov . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It after if item 27 is marked other than "natural", or items 23a or 28a-f sho itiny or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 K Yes 2 No MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12205 Windbrook Dr. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Computer Technician years ENJVC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Burks Gloria Haskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Ray Bynum/Husband 12205 Windbrook Dr. Clinton MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 02/20/2010 Wilson, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? after death.

| Director: After this certificate | 2 WNo 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှ 1 🗌 Yes 2 🖭 No Other: 1 🔲 Inpatient 2 🖼 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Certificate: 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physicien: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier **completed** within 2 To the I only one) Certifying Nurse Practioner: To the best my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	ate of Maryland / De			/giene					
			Registrar Certificate of Death Reg. No. 2									
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  JANICE	BURRIS		2. Date of D Month FEBRU	Day Year	3. Time of Death 2:18 P				
7	Examin		4a. Facility Name (if not institution, give street a	nd number)	4b. City, Town, or Locati		4c. County of Death					
			SHADY GROVE HOSPIT		ROCKVILLI		MONTGOME					
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. last birthday	/) If Under 1 Year If Un Months Days Hou	rs Min. 8. Date of Bi (Month, D JUNE	orth 9. Birth 9. Birth 9. Birth 21 1945 ALAI	place (State or Foreign ntry) BAMA				
	nd thow	2	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits				
	Aaryla 8a-f s tified	rect	MD MONTGOMERY	GAITHE	RSBURG			1  Yes 2 □ No				
	ith the N 23a or 2 It be no	Funeral Director	10e. Street and Number 889 HIDDEN MARSH STE	REET	10f. Zip Code 20877		10g. Citizen of What Coul	ntry?				
	items 2		11. Marital Status 12. Wa		Was Decedent of Hispanic     If Yes, specify Cuban, Mex		1 11 110000					
920	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 Married 1 If Y	Yes 2 X No es, Give ar or Dates.	1 ☐ Yes 2 🔀 No Spec	•	Black, White, Specify: BLA					
2-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade com	pleted) (Giv	cedent's Usual Occupation re kind of work done during n	most of working	16b. Kind of Business In	dustry				
121	within 7 giene. ner than t, the M	Com	Elementary/Seconday (0-12) Col	lege (1-4 or 5+)	DO NOT use retired) OGRAM ANALY	ST	GOVERNME	NT				
d 2	filed w al Hygi d othel	Be	17. Father's Name (First, Middle, Last)	7 110		lother's Name (First, Middle	1					
ylar	ild be filk Mental narked c	욘	TOM CONLEY			SUSIE BO	YD					
Maryland 21215-0036	1 and 2 should be fil f Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type, Prin MICHAEL BURRIS/SON	19b. Ma 889	illing Address (Street and Nui HIDDEN MARSH	mber or Rural Route Numb STREET GAIT	er, City or Town, State, Zip ( HERSBURG , MAR	YLAND 20877				
Baltimore,	age 1 and ant of Heal at: If item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Remove		position (Name of rematory or other place)	Date	20c. Location - City or To					
altin	permit. Page 1 Department of Imp. rtant: If i any it jury or or		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee		LF CREMATORY  22. Name and Address of Fa		RIVERDALE,M NKINS FUNERA					
<u>~</u>	on a me		JA /		7474 LANDOVE		VER, MARYLAND					
	ate be executed  Medical  Examiner  the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate barso. Enter Underlying Cause (Disease or iinjury that initiated events	SEPTIC SHOCK Due to (or as a consequence of): PNEUMONIA Due to (or as a consequence of): METASTATIC LUNG Due to (or as a consequence of):	CANCER			Interval Between Onset and Death				
	death certific he attending ped for use as	Physician/Medical Examin	in the past 12-months?		Ectopic pregnancy     Other (specify)		23d. Date of deliv Month	ery Day Year				
ds, P.O.	The law requires that the de ate has been signed by the page 2 should be detached	ted by Pl	Part II. Other significant conditions contributin	ng to death but not resulting in the	a underlying cause given in P	Loo. Bid	tobacco use contribute to the	77				
Division of Vital Records,	The law ate has page 2	Completed by				24a. Was aut perf 1 □ Yes	an 24b. Were auto prior to co ormed? 1 XNo 1 Yes	psy findings available mpletion of cause of $2\mathrm{X}$ l No				
ita	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital		_ Other	Death (Check only one)						
) t	y Phys er this eral di	e: 10	Λ	1 X Inpatient 2 ☐ ER/Outpat Date of injury 28b. Time	of 28c. Injury at		idence 6  Other (Specify how injury occurred	)				
Ou	ending sath. ir: Afte	ficat	1 XNatural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury	work? M 1 ☐ Yes 2	2 □ No						
ivisi	I or Atter de after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location ( City or To	Street and Number or Rural wn, State)	Route Number,				
	To the Nospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the	the best of my knowledge, deat the basis of examination and/or invi	estigation, in my opinion, deatl	h occurred at the time, date	and place, and due to the car	use(s) and manner stated.				
	To the Within 2 To the comple	Σ	only one) 3 $\square$ Certifying Nurse Practi 29b. Signature and title of certifier	oner: To the best of my knowledge	29c. License number		29d. Date signed (Month,					
			1 All un	MI. 1/	D65132	2	FEBRUARY 6	2010				
· /	, 4		30. Name and address of person who complete	d cause of death (Item 23a) (Type		ROCKVILLE, MA	ARYLAND 2085	0				
	Stat Registra		31. Date filed (Month, Day, Year) FEB 1 6 2010 Sincer	32. Registrar's-Şignater	•	,						
			The LUID CONSULT	- 1 - 7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH C9155/12/2011 IIII For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year /Medical February 2,2010 5:00A 4a. Facility Name (If not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Thomas More Medical Complex Prince Georges Hyattsville 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 2, 1930 Birthplace (State or Foreign Country) 1 M M 2 □ F Months Days Hours 451-36-1531 Director 79 Texas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Evantment must be notified once. **Funeral Director** MD PG 1 XYes 2 □ No Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3420 Rickey Ave. #235 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 XYes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 2 No þ 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contract Manager Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Burton ဥ Marjorie Riggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 790 Concourse Village West Bronx, NY 10451 <u>Terraine Manley/wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/17/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. Towar 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Par Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician² /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transi and I Due to or as a consequence of) P.O. Box 68760, physiciar Physician/Medical as the attending p for use as 1 nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the a d be detached for Month 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Doknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an autopsy performe 21 the Hospital or Attending Physician: 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2000 1 ☐ Yes Certification: To Other: 1 Inpatient this 2 ER/Outpatient 3 DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending Accident investigation 1 ☐ Yes /2 ☑ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 2 Medical Examiner one) 29b. Signature and title of certifier 29c. License number -5-2010

Registrar
DHMH 17 Rev 1/2001

State

31: Date thed (Month, Day, Year)
FER 1 6 2010

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1-State Amend Item 23aPtII pr dr.,g90I	03/16/2010dhb ertificate of Death	лептаг нудг	ene .g. No. 2010	05777
Physici		Decedent's Name (First, Middle, Last)  UALTER SAMSUNDER BIFAT		2. Date of Death Month Febuary	Day Year 2 2010	3. Time of Death
Med Exami		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	7 6 50 8 9	4c. County of Dea	
Funera Director		5. Social Security Number 6. Sex. 1 M 2 □ F 6. Yrs.   ast birthday,   2 1 9 - 41 - 77/3   1 M 2 □ F 6.   6 4 Yrs.		8. Date of Birth (Month, Day,	Year) . Co	thplace (State or Foreign untry)
Maryland <b>28a-f</b> show	Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or L  MD  ChareLes  Wald				10d. Inside City Limits 1  Yes 2 □ No
with the 23a or 2	eral Di	10501 Starlight Place	10f. Zip Code 20603	1	0g. Citizen of What Co	ountry?
ING 21215-50036  filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	d by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  12. Was Decedent Ever in U.S.  Armed Forces?,  1 □ Yes 2 ☒ No  If Yes, Give	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Z1Z15-0036 within 72 hours after giene. er than "natural", o	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business	,
d Z1Z ed withir Hygiene other tha ent, the	Be Co	17. Father's Name (First, Middle, Last)	Minister  18. Mother's Name	e (Eiret Middle M	Religio	n S
Maryland 2 should be filed th and Mental Hy 77 is marked oth traumatic event	5	Ramnanrain Bipat	Rajmo		Garib	
_ = -4 -		19a. Informant's Name/Relationship (Type, Print)  19b. Mai  Jean Bipat / WiFe 105	ling Address (Street and Number or Rura 101 Starlight P			,
IMORE, I Page 1 and 2 ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Removal from State  20b. Place of Disposered Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company	position (Name of ematory or other place)	Date 2	20c. Location - City or	Town, State
<b>Baltimore,</b> permit. Page 1 and Department of Hea Important: If item any injury or othe once.			22. Name and Address of Facility 51	rickland	Funeral :	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	s 500 Allentown Ru ter the mode of dying, such as cardiac o			Approximate Interval Between
Pnysician Medica	-	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	e Brai Injung			Onset and Death
Examine		Sequentially list conditions, b. Cardio quie	- Shock	1		1 meek
cuted ind transit	Examiner	flag, leading to himsolate cause. Enter Underlying Cause (Disease or injury that initiated events	y Palli			1 warf
/ <b>60</b> icate be exe physician as the burial-	ledical E	resulting in death) Last  Due to (or as a consequence of):  d.				
Division of Vital Records, P.O. Box 68 /60  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:   23c. If yes, outcome of pregnancy   1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
s that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the Ischemic Cardiomyopathy (Severe)	underlying cause given in Part I.		acco use contribute to	
ords v require s been si should	Completed by	Multi Organ Failure		1 ☐ Ye	24b. Were au	robably 4 Unknown topsy findings available
HeC The lav cate has	Comp	Decompensated Congestive Heart Failu	re	autops perforn 1 🗆 Yes 2	ned2r death?	completion of cause of
VITAI ysician is certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1  Inpatient 2  ER/Outpati	26. Place of Death (Check		nce 6 Other (Spec	rifu)
DIVISION OT VITAI HECONAS, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been sig ed in by the funeral director, page 2 should b	Certificate: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Time injury	, Trailing Fie	28d. Describe hov		,
DIVISI tal or Att rs after de al Directe ed in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
e Hospi n 24 hou e Funer	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and/or inversional of the basis of examination and or inversional of the basis of examination and or inversional of the basis of examination and or inversional of the basis of examination and or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inversional or inver	stigation, in my opinion, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
To th within	-	29b. Signature and title of certifier  Maurin, MD	29c. License number A T 2 4 3 8 9 4	29	2,2,20	h, Day, Year)
R1		30. Name and address of person who completed cause of death (Item 23a) (Type		A		_
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2/7/2010 THOMAS BERNARD BAZEMORE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON 8. Date of Birth **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. 1 X M 2 🗆 F Hours (Month, Day, Ye. Director 579-82-1283 45 Murfreesboro.NC Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4905 Wickham Drive 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify. 3 - Widowed 4 - Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) FBI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Roosevelt Bazemore Audrey Gatling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benita Wimbush Bazemore / Wife 4905 Wickham Drive Temple Hills, Maryland 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or 2/15/2010 Landover, Maryland <u>Harmony Memorial</u> 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestvlle, Maryland 20747 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached 1 9 ☐ Unknown g Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 certificate has autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ᅆ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Box 68760

P.O.

Records,

of Vital

Division

ack

Name and address of person who completed cause of death (Item 23a) (Type, Print)

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0:30 R Day 08 Year 10 Month 02 Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Talcome. Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, August 3 Min. Washington, 1 X M 2 □ F 81 Yrs. 1928 215-20-3499 Director Usual Residence of Decedent 10d, Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 X Yes 2 No Berwyn Heights Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò must be r Funeral 20740 USA 8710 Edmonston Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ò þ 1 Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: If Yes, Give 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Meat Cutter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margarete Schad Paul Baranek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15605 Peach Orchard Road, Silver Spring, MD 20905 Colleen Holladay / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Brentwood, Maryland 2/20/2010 Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birting
Pregnant
Unknown in the past 12 months? Month Day Pregnant at time of death Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) examine? Hospital Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work? 1 🗆 Yes 2 🗌 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 _ 29d. Date signed (Month, Day, Year, 29b. Signature and title UZ

State Registrar 30. Name and addre

1 6 2010

7600 Carroll Avenue, Takoma Park, MD 20912

person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		- For State		Certific	cate of	Death				eg. No.		
Physicia		le <b>gistrar</b> 1. Decedent's Name (First, Midd	lle,Last)						Date of Dea Month	ith Day Ye	ar	3. Time of Death
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		4a, Facility Name (if not institution			41	o. City, Town, or Lo	ocation of	Death		4c. County	of Deat	h
		9 Prairie Rose Court				Gaithersburg				Montgo	mery	
		5. Social Security Number	6. Sex 7. As	ge (In yrs. last bi	rthday)	If Under 1 Year	If Under	24Hrs.	B. Date of Bi	rth (MM/DD/YYY	Y) 9. Bi	irthplace (State or
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		Usual Residence of Decedent		Tro. 00 T.	1 4:							10d. Inside City Limits
any		10a. State 10b. County		10c. City, Tow								1 Yes 2 No
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or 2	Director	9 PRAIRIE ROSE	E COURT			20878				U.S.	Α.	
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Hyg	O							RRIN		ACKSON		
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MD id 2 sho lith and m 27 is aumati		LENA LLOYD BU'	TLER/WIFE			tion (Name of cem			Date	20c. Location	1 - City o	or Town, State
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 X Burial 2 Crematic	on 3 Removal from S		atory or oth		lotory,				,	
noi ant of		4 Donation 5 Other 3			NSVIL	LE CEMETI	ERY	3-4-	2010	CROWNS	SVIL	LE, MD
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Physician		23a. Part I. Enter the dise se, of	or complications that cause	ed the death. Do	not enter th	ne mode of dying,	such as ca	rdiac or r	espiratory a	rrest, shock, or h	neart	Approximate Interval Between Onset and
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	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	sequence of):								
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Box 68 e death certifi the attending	ici		Indian accord	at time of death	5 Ot	her (Specify)						
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Divi pital or ours afte teral Dir	ertification:		Annual on the	residen	ce				Gaith	ersburg	MD	
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Ω		30. Name and address of pers				1 Penn Street	Baltim	ore. Mi	21201			
1		Donna M. Vincenti,					, <u></u>	J. J, 191L				
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				State of Ma	ryland / D	epartment o	f Health	and Men	tal Hygie	ene		
			For State Registrar		-	Certificate d				.No. )	In	05781
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	the Hygiene in the mean way hand the line way hand that Hygiene do other than "natural", or items 23a or 28a-f show event, it a Medical Examinar mast be rediffed at	Funeral Director	10e. Street and Number 28 Castle Dr.			10f. Zip Coo 218			100	USA	mat Coun	ury !
=	ns 23	eral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent If Yes, specify (		igin? (Specify	Yes or No-		- Americ	ean Indian,
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ň	e atte	icla	in the past 12 months? 1 □Yes 2 █€No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death time of death	3 ☐ Ectopic pregr 5 ☐ Other (specif				Mo	nth	Day Year
л О	by th	hys	9 ☐ Unknown					E		<u> </u>		the second of death?
ທົ່	igned igned be de	þ	Part II. Other significant conditions of		)	the underlying cause	e given in Part	1.			27.000	he cause of death? bably 4 ☐ Unknown
Records,	nedun een s nould	Completed	- Acute V		love_						1.0	
ပ္ပ		nple	Diobetes	mellitu	7.7				24a. Was an autopsy performe	, F	Nere auto prior to co death?	opsy findings available impletion of cause of
_ '	icate har, page								1 ☐ Yes 2	DXXIO 1	Yes	2 🗀
VItal	sician: The law certificate has t irector, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:	nt 0 🗆 EB/Out	patient 3 DOA	Othor	e of Death <i>(Cf</i> Iursing Home		_	or (Cassi	6.)
0	Attending ruysicians or death ector: After this certific by the funeral director,	μ̈́	27. Manner of Death	28a. Date of Injui (Month, Day			Injury at Work?			v injury occurr		
<u></u>	ath r: Aft	atio	Natural 5 Pending 2 Accident investigation		, rear) III		1 ☐ Yes 2 ☐	]No				
DIVISION	er der recto	Certification: T	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	iry - At home, fan	m, street, factory, off	ice	28f.	Location (Stre City or Town,	eet and Numb State)	er or Rur	al Route Number,
ָ ב	rs aft	Cer										
:	s nospital at Auentung Fripsicalis. 24 hours after death s Fundral Director: After this certifical etely filled in by the funeral director, is	edical		ysician: To the best on hiner: On the basis of and manner sta	examination and							
	within 24 hours after To the Funeral Difference Completely filled in	Med	29b. Signature and title of certifier	and manner Sta		29c. Li	cense number		29	d. Date signed	d (Month,	Day, Year)
	- 5 - 0		1	20000		H	6442	8		02/11	120	10
			30. Name an address of person why			Type, Print)		973	33 Hea	02/11 1th uay	Dri	re
12	16		Jason Szymala	, DO At	lantic 6	en erol H	ospital		Berli	n, M	021	811
			31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		V					

State Registrar

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DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 08:53 AM February 10 2010 Larry Wayne Brown /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Union Hospital of Cecil County **Elkton** 9. Birthplace (State or Foreign Country) F1kton Mary Land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours **™**M 2□ F Yrs. 59 March 28,1950 **Director** 218-54-3624 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo E1kton Maryland | Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 Funeral 1 Pinder Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√√No Specify. White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental College (1-4or 5+) Elementary/Secondary (0-12) Power Washing Company 12 Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilma Jean Heideman John Earl Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Pinder Avenue, Elkton, Maryland Donna Boyd/Domestic Partner 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ other (Specify) 3 Removal from State 13, 2010 Newark, Delaware Mayerdale Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final unknown **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to inninediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner law requires that the death certificate be executed Exami and burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Y Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform 2 No 1 ☐ Yes 1 Yes 2 No certificate Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 \( \bigcap \) Nursing Home \( 5 \bigcap \) Residence \( 6 \bigcap \) Other \( \bigcap \) Specify) 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 ☐ Yes P 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, E

State Registrar

31. Date filed (Month, Day, Year) FEB 16

29b. Signafure and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 BOW STREET ELKTON IS MO 32. Registrar's Signat

29c. License number

29d. Date signed (Month, Day, Year)

10,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 Miquel Buezo 7:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 600 Arbor Trace Drive Apt 203 <u>Frederick</u> Frederick Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2 □ F Months Days Hours Min. July 5, 1930 Country) 79 Director 223-45-2754 Bolivia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland all Hyglene.
In Hyglene.
d other than "natural", or items 23a or 28a-f shover, the Medical Examiner must be notified at event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick 1 Yes 2 No Frederick 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Arbor Trace Drive Apt 203 21703 Bolivia 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1X Yes 2 ☐ No Specify: Specify: White 3 Ulidowed 4 Divorced Bolivian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Abraham Buezo Eleodora Urquieta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr. once. Gilmar Buezo/son 600 Arbor Trace Drive Apt 203 Frederick, MD 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/15/2010 Woodbine, Maryland . Sign pore of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M Thomas etinail M00957 MD 21029 23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any modification cause. Enter Underlying Cause (Disease or linjury that initiated events Examine consuluence of): or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ate has been signated bage 2 should b Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 1 Yes 2 No 1 🗆 To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 12 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Waye CRLP 25+1 Taket 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Belcher Margaret Duncan 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Howard County General Hospital 9. Birthplace (State or Foreign Country) 1-17.7 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Months Days Min 2/47/1932 ar) WV 78 Director 235**-**46**-**1493 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Item Modical Examples and injury or other traumatic event, Item Modical Examples and injury or other traumatic event. 1 Yes 2 No Director MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 12214 Etchison Road 21042 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo Maryland 21215-0036 Specify: If Yes, Give Year or Dates: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (3-4or 5+) Medical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Morton ပ Carl Duncan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Henry V. Belcher - Husband 12214 Etchison Rd. Ellicott City, MD 21042 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Colonial Grove Mem. Pk 2/22/2010 Virginia Beach, VA 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Fill eral Service Licensee mone 4112 Old Columbia Pike Ellicott City, MD 21043 M00845 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) tsophagene Cancer Years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ₩ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☑ No 1 □ Yes 2 000 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 11No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

32. Registrar's Signature,

DHMH 17 Rev 1/2001

10700

29c. License number

D 53636

29d. Date signed (Month, Day, Year)

charter over Columbia MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** FEB 1404 DAUID VERNON RARDETT 11 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia 1 Year | If Under 24 Hrs. Howard County General Hospital Howard If Under 1 Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Sex 1 M 2 □ F **Funeral** Months Days 402-64-5751 63 Director 8/27/1946 KY Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Evaning must be notified at 1 □Yes 2 No Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5802 Bluesky 21075 United States Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates:1966-68 Specify: þ 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Education Š÷ Media Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David William Barnett Jr. ည Annis Stephens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Elkridge, MD 21075 5802 Bluesky Margo Barnett - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If iter any Injury or ott once. 1 → Burial 2 □ Cremation 3 □ Removal from State 19/2010 Meadowridge Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licensee M00845 4112 Old Columia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician PROBABLE DYSRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIAC ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed anding physician and use as the burial-transit EXECTION Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificate has been s al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

4 41

Registrar DHMH 17 Rev 1/2001

State

MATTHEW 80 31. Date filed (Month, Day, Year) 32. Raistrar's Signature FEB 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TEB, 11,2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maryam Bidmeshke		nent of Health and Mental Hy cate of Death	2010 0010						
	Registrar  1. Decedent's Name (First, Middle,Last)		Reg. No. 2. Date of Death 3. Time of Death						
/Physician Modical Examiner	Maryam Zarei Bidmeshkei		Month Day Year February 19, 2010 2024 hrs						
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death  Montgomery						
	Shady Grove Adventist Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24Hrs.	B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Days Hours Min.	Mar 22 1965 Country Iran						
	Usual Residence of Decedent		10d. Inside City Limits						
w any	10a. State 10b. County 10c. City, Tow		1 Yes 2 X No						
yland -f sho once.	MD Montgomery Germa  10e. Street and Number	antown  10f. Zip Code	10g Citizen of What Country?						
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	13532 Sanderling Place	20874	U.S.A.						
with the ss 23a se noti	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Sp	ecify Yes or No- 14. Race - American Indian, Black,						
r death with or items 23 must be no	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto							
ral", o	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:  a. Decedent's Usual Occupation (Give kind of w	Specify: White						
hours "natu	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retir							
0036 within 72 hour giene. Medical Exan		Homemaker	Own Home						
5-0036 led within 7 Hygiene. I other than the Medica	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)						
2121 build be fill Mental B marked ic event,	Hossein Zarei Bidmeshkei		h Sharifi Rural Route Number, City or Town, State, Zip Code)						
re, MD 21 I and 2 should I health and Me fitem 27 is ma or traumatic ov			1. Germantown MD 20874						
mand 2 shorten 2 shorten 27 is traumati	20a Method of Disposition 20b. Place	e of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State						
ages l nt of F	1 X Burial 2 Cremation 3 Removal from State Behe	natory or other place) esht Zahra 03/	/5/2010 Tehran, Iran						
Baltimore, permit Pages I an Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify: CEI 2 Ignature of Funeral Service Licensee	netery  22. Name and Address of Facility Lo	udoun Funeral Chapels						
	nothing My bridge Well osc	7 158 Catoctin Cr	SE Leesburg VA 20175						
Physician /Medical	23. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line		Death						
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Alcohol & combined drug (Hydroxyzine & salicylate)  Due to (or as a consequence of): intoxication								
	Sequentially list conditions, b	Intoxication							
ner									
red Insit	Citisease or injury that initiated events resulting in death). Last Use to (or as a consequence of):								
executed ian and ial - transit	d								
2.   ਡ ਡ ਫ	X UNPENDED AMENDED 23a 27,28	a-f,per ME g902 4/15/	10 TT 23d. Date of delivery						
68760, certificate be inding physici se as the buri	F FEMALE:  23b. Was decedent pregnant in the past 12 months?	cy 2 Fetal death 3 Ectopic pregna	N.						
ox 687 eath certific e attending if for use as the	4 Pregnant at time or death	5 Other (Specify)							
by the attentiched for us	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
of Vital Records, P.O. ng Physician: The law requires that the Noter this certificate has been signed by meral director, page 2 should be detach in: To Be Completed by P.			1 Yes 2 No 3 Probably 4 Vunknown						
ital Records, P.C ician: The law requires that sertificate has been signed rector, page 2 should be deter Be Completed by			24a. Was an autopsy available prior to completion of cause of						
E law te has lege 2 st			performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No						
I Re Int The Int The Int. Page Co	25. Was case referred to medical	26.Place of Death (Check	only one)						
F Vita Physicia or this ce ral direc	1 Yes 2 No	t/Outpatient 3 ✓ DOA Other Nursin							
n of \ding Ph; After the funeral	(Month, Day, Year)	b Time of Injury 28c. Injury at Work?	subject ingested alcohol and						
Sior Attend death cetor:	Pending 2 Accident Investigation 2/19/2010 7 28e. Place of Injury - At home	drugs 28f. Location (Street and Number or Rural Route Number, City							
Division or spital or Attending tours after death oneral Director: After filled in by the fune Certification:	or Town, State)13532 Sandering P1 Germantown, MD								
	4 Homicide (Specify) residence  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To the Ho within 24 To the Fu completel	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of cartifier.  29c. License number 29d. Date signed (Month, Day, Year)								
A STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF S	29b. Signature and title of certifier	29c. License number O.C.M.E. OCM							
	I feedow M. K. XTR., s.	u.,),							
12	30. Name and address of person who completed carse of death/(Item 23 Theodore M. King, Jr., MD. Assistant Medical Exa		re, MD 21201						
State	22 Participante Signatura	h had the							

10-01540 Ro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

odney Collins		St	ate of Maryla	and / Depa	irtment of	f Health	and	Menta	l Hy	giene	2.0		05787
		1- For State Certificate of Death Registrar  A Paradral's Name (First Middle Last)						12	Reg. No.			Time of Death	
Physicia lical Exami		1. Decedent's Name (First, Middle, Last)  Rodney Steven Collins							Month Day Year			0937 hrs	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dec.  96 Ohio Avenue  Earleville						Death	4c. County of Death Cecil				
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under		If Under :	24Hrs.	8. Date of Birt	h(MM/DD/YYYY)		elace (State or
Funeral Director		216-19-9449	1 X M 2 F	23	Yrs	Months	Days	Hours	Min.	08/17	/1986	Foreign Count	^{try)} Maryland
		Usual Residence of Decedent											Od. Inside City Limits
w any	- 1	10a. State 10b. County		,	Town or Locat	ion							Yes 2 X No
Aaryland 28a-f show 1 at once.	io	Maryland Cec	<u>i1</u>	E1	lkton	Link W. O				Lac	g. Citizen of Wh		
Mary r 28a- ed at	Director	10e. Street and Number				10f. Zip C							
th the 333 or		4380 Telegrap		adest Ever in II	6 13 10/6		921	anic Origin	2 ( Sno	cify Yes or No-	United		n Indian, Black,
ath wi	Funeral	1 X Never Married 2 Married Armed Forces?				13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto					White		.,
rer de ", or i		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify				specify:			Specify:	Whi	te		
ours at atural	d by	or Dates:  152 December 5 Studies (Specific poly biphote grade completed) 152 December 5 Usual Occupation (Give kind of											
6 72 ho	Completed	Elementary/Secondary (0-12)	College (1	1-4 or 5+)						,	0		
within jene.	Ĕ	12	1 201		Concrete Finisher				First Middle M	Construction irst, Middle, Maiden Surname)			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	ادہ	17. Father's Name (First, Middle Rodney DeMond					"			Kay Py			
2121 uld be fil Mental F marked	TO B	19a. Informant's Name/Relations			19b. Mailin	g Address	(Street				ber, City or Town	n, State, Z	(ip Code)
C 2 2 3		Beverly Collin	s-Fawcett/							Elkton,			
	П	20a. Method of Disposition  1 Burial 2 X Cremation	2 Pomoval fr		Place of Dispos crematory or ot		of cem	etery,		_{Date} uary	20c, Location -	City or To	own, State
mol Pages eent of ant: I		4 Denation 5 Other S	necify:	R.	A. Ferr	is & Co	., Iı	nc. 2	23,	2010	West	Ches	ster, PA
Baltimore, permit. Pages l at Department of Het Important: If ite	. 1	21. Si. ature of Funeral Service	Licensee		22. I H	Name and A icks h	ddress d Iome	of Facility for	Fun	erals,	P.A.		
		Doned.	8. Hul	Salved the death	Do not enter t	03 W.	Sto	cktor	St.	reet. E	1kton 1	MD 2	21921 Approximate Interval
Physician /Medical		failure. List only one cause	on each line.										Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		hopneum a consequence o		SOCIA	Lea	WILL	OXy	codone	use		<u> </u>
		Sequentially list conditions,	b									_	
	iner	if any, leading to immediate cause. Enter Underlying Cause		a consequence o	of):								
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50, te be e nysicia e buria	sician/Medical	IF FEMALE:	23c. If yes.	a,PII,2	7,perm,	E g90	2 4/	22/10	) TT		23d. Date of	delivery	
Box 68760, edeath certificate be the attending physicied for use as the buri	an/N	23b. Was decedent pregnant in t past 12 months?	he 1 Live I	birth	2 Fe	etal death	3	Ectopic p	pregnar	су	Month	Day	y Year
OX (eath ce attend	sici	1 Yes 2 No 9 Ur	known 9 Unkn	nant at time of de lown	eath 5 O	ther (Specia	fy)						
D. B the de by the	Phy	Part II. Other significant condi			esulting in the	underlying o	ause gi	ven in Part	1.	23e. Did to	bacco use contri	bute to the	e cause of death?
P.O. es that the signed by be detach	d by	cardiomegaly	7							1 Yes	2 No 3	Probal	bly 4 🗸 Unknown
ords, w requir is been s should	etec									24a. Was autop	an 24b. V	Vere auto	psy findings available npletion of cause of
SCOI re law te has ge 2 sl	mp	performed? death?									2 No		
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Vita ysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	] ER/Outpatien	t 3 DC	OA C	Other ₄	Nursing	Home 5	Residence 6	Other: 9	Scene
ion of Vending Ph. eath.	n: T	27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?								28d. Describe how injury occurred			
sion trend death. ctor: y the f	atic		ding estigation		<u></u>			es 2	-	296 Leastion /6	Street and Number	or Or Pura	Poute Number City
Divisor A safter I Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Dire	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, City or Town, State)											
23d. Date (									e(s) and manner	as stated			
									and place, and d	d place, and due to the cause(s)			
7.18.18	Me	29b. Signature and title of certif				29c.		number			29d Date sign		
		Allen	rasself,	MY)			O.C.N	Л.Е. 			February 2	1, 2010 ———	
		30. Nam Ind address of perso Melissa Brassell, MD				Penn Stre	et R	altimore	MD 1	21201			
		21 2 1 2 1 2 1 2 1 2 2 2		Registrar's Signat		CHI OU	- A		, 1410	_ ,,			
S Reais	tate		0.1.2010	M	A	hand.	1						

			For State Registrar	State of Mai	-	epartment of C <i>ertificate o</i>		ıd Mental Hy	giene Reg. No. 2	010	05788
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day							Year	3. Time of Death
-	/Media	cal	BARBARA ANN CROSS FEBRUARY 1 2010							2010	1:19 P M
	Examir	ier		ility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of  CHEVERLY  PRINCE							RGE'S
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birth	day) If Under 1 Yea	If Under 1 Year   If Under 24 Hrs.   8. Date o			Coun	place (State or Foreign htry) HINGTON, DC
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town of	or Location		-		1	0d. Inside City Limits
	Marylan F show	ţō	DC		WASHI						1 Yes 2 No
	or 28a	Director	10e. Street and Number		WADIIII	10f. Zip Code	1		10g. Citizen o	of What Coun	ntry?
	ath will		4406 QUARRELS S'	TREET N.E.		200			USA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar mast be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 【※*Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent o If Yes, specify Co 1 ☐ Yes 2 ☒ N		? (Specify Yes or No Puerto Rican, etc.)	o- 14. F B <i>Sp</i> e	Race - Americ Black, White, e	
2-0	72 hou natura ical E	sted	15. Decedent's E (Specify only highest gr	16a. D	Decedent's Usual Occ	upation	f working	16b. Kind of	16b. Kind of Business/Industry		
21215-0036	2 should be filed within 7 and Mental Hygiene. is marked other than "n aumattc event, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	) ()	Give kind of work done during most of working ife. DO NOT use retired)  CNA			PRIVATE		
Maryland	be file	Be	17. Father's Name (First, Middle, Last	")				Name (First, Middle	e, Maiden Surn	name)	
ry	should be fand Mental Is marked of Iumatic eve	2	MORRIS BROWN  19a. Informant's Name/Relationship	(Time Print)	19b N	Mailing Address (Stre	ANNIE		her City or Tou	wn State Zin	(Code)
	1 and 2 s Health ar em 27 is ther trau		RUSSELL BROWN/SO			04 21ST S					
Baltimore,	of He of He f Item r othe		20a. Method of Disposition	7.D	20b. Place of C	Disposition (Name of crematory or other p	/ace)	Date	20c. Locatio	on - City or To	own, State
ij	tment of I	-	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			Y CEMETERY	2 2,	/13/2010	LANDO		
Ball	permit. Pages 1 and Department of Health Important: If Item 27 In Important: or other tr		21. Signature of Forneral Service Lice	nsee		22. Name and Add 7474 LANI		J. B. JE AD LANDOV			L HOME 20785
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  ACUTE RESPIRATORY FAILURE  Approximate Interval Betwee Onset and De								Approximate Interval Between Onset and Death
-			resulting in death)	Due to (or as a	consequence of	:					
	Lxammer	e.	Sequentially list conditions,	D	Consequence of						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	COPD							
oʻ	an an	Еха	resulting in death) Last	Due to (or as a	consequence of)	:					·
68760,	ificate be executed g physician and is the burial-transit	edical		d							
O. Box 6	ath certi ettending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)				Date of delive	ery Day Year
σ.	that the dended by the detached		Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying cause	given in Part I.	23e. Did	tobacco use c	ontribute to the	he cause of death?
rds	w requires been sign should be	ed by	<u>HYPERTENSIVECA</u>	RDIO VASCUL	AR DISE	ASE		1 🗆	Yes 2 □ No	o 3□ Prot	oably 41 Unknown
of Vital Records,	The law requirate has been page 2 should	Completed	CONGESTIVE HEA	RT FAILURE				24a. Was		Ib. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of 2√□No
/ita	sician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?	I I a mittal				Death (Check only			
of	Physical direction	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury		atient 3 DOA		ing Home 5 ☐ Res	how injury occ		fy)
	nding Phy th. : After this s funeral o	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day,	Year) Inji	ury \ \	ork? □Yes 2□No		riow injury occ	curred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined			n, street, factory, offic	е	28f. Location City or To	(Street and Nu wn, State)	ımber or Rura	al Route Number,
	To the Hospital within 24 hours a Fo the Funeral Completely filled	Medical (		hysician: To the best of miner: On the basis of and manner state	examination and						
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date sig		
	- 4		heurs l	vmars	hall		5618		02-0	12-	2010
	7		30. Name and address of person who	·			# 120	UV A TOTO C 17 T T T	TE MADS	71 4 117	20792
	Sta	ite	LEWIS W. MARSH. 31. Date filed (Month, Day, Year)			CREST ROAL	# 130	UIAIIDVIL	LE,MAKY	LAND	20782
	Registi		FEB 1 6 2010	Prese A.	gare						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0^{Mo} 12:30a M 29 2010 Charles Theodore Coleman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death P.G. 904 Kings Valley Drive Bowie 8. Date of Birth (Month, Day, Year) 07/16/1957 Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. 1 € M 2 □ F Hours. Wash DC 52 Director 577-76-4294 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Bowie 1 
✓ Yes 2 
☐ No MD P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 904 Kings Valley Drive Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates marked other than "natur matic event, the Medic | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. J.H.M. Supervisor 2yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked o any injuy or other traumatic eventoes. 2 Mary Smith Cleophus Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
904 Kings Valley Drive, Bowie, MD. 20721 Cynthia M. Best-Coleman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Suitland, MD 2/5/10 Lincoln Memorial 4 ☐ Donation 5 ☐ Other (Specify) 420 H St.NE. Signature of Funeral Service Licensee 22. Name and Address of Facility B.K. Henry Funeral Home Wash., DC.20002 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . Enter the disease, or complications that shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ an Ce disease or condition Medical resulting in death) Examiner Equentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the at d be detached for 2 No Unknown Division of Vital Records, P.O. Other significant conditions contributing to treath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N certificate 2 No ours after death.

eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 🗋 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 🗌 Yes 2 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completed fil 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title certifie MU

State Registrar 31. Date filed (Month, Day, Year) FEB 1 6 2010

FEB

2010

12150 Annapolis

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of death (Item 23a) (Type, Print)

ompleted cause

P.A.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 5, Day 2010 Loretta A. വിഷി 8:52 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Mon top mery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Hours Min Jahonth 5 Day, 1918 397-34-3453 Wisconsin 92 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County hours after death with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified Maryland 1 Yes 2 Ty No Montgomery Kensington 10e Street and Number ò 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 3522 Nimitz Road 20895 JSA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other th other traumatic event, the Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Lafayette Fremont Bertha Melvina Follev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 arus ...
Department of Health a
Important: If item 27 i Barbara Colwell McMahon/Daughter 18019 Sunset River Court, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State Feb1013 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service License 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ARDIOMYO disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury -tran that initiated events resulting in death) Last and Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No P Month Day Year Pregnant at time of death 5 Other (specify) signed by the sid be detached f ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 prior to completion death? has page 2 After this certificate 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Vithin 2 3 only one 29b. Signature and title of certific D0030414 ú

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who

FEB 12

31. Date filed (Month, Day, Year)

8101

PRINCE PHILIP DR. DLARY

completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 7^{ay} 2016^{ai} 5:45 а м Alvado Francis Campbell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Arcola Health & Rehab. Center Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₺ M 2 🗆 F July Day, Year 1930 Bountry) 578-40-4081 79 Director Usual Residence of Deceden 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director District o 1 Yes 2 No Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 USA 3700 North Capitol Street, NW 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces?

1 64 Yes 2 □ No
If Yes, Give 1951–53
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Technician N.I.H. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Leroy Campbell Mary Flossie Plater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
217 Northwest Terrace, Silver Spring, MD 20901 permit. Page 1 and 2 sh Decartment of Health an Important: If item 27 is any injury or other trau once. Phyllis Campbell Toliver/Siste 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery Feb. 1 2010 20c. Location - City or Town, State 12, 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Washington, DC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hypertension Medical Due to (or as a consequence of); Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No detached the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? δ Dementia should be Division of Vital Records, The faw requires 1 Yes 2 No 3 Probably 4 B Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed^a certificate 1 Yes 2 No 2 X No 25. Was case referred to medical Hospital or Attending Physician: funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 X Natural 5 Pending work? To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 3

30. Name and address of person wh Sandeep Sharma,

31. Date filed (Month, Day, Year) FEB 12 2010

29b. Signature and title of certifie

only one

D64624

completed cause of death (Item 23a) (Type, Print) MD 743 Summer Walk Drive, Gaithersburg, Md 20878

29d. Date signed (Month, Day, Year)

February 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 **Physician** 11, Feb. 8:51p M Leonard Wesley Conrad /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept. 8, 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1 M 2 □ F MD Sept. 220-14-7602 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Experience to redified at 1 ☐Yes 2 ☐ No Director Colora MD Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21917 108 Colora School Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 March 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Test Driver Government permit. Pages 1 and 2 should be filed v Department of Heath and Mental Hygic Important: If item 27 Is marked other i any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Andrew Conrad Bertha Astle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 108 Colora School Rd. Colora, MD 21917 Nancy Conrad/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/21^{Date} 010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signifure of uneral Service Licens 22 Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun, MD 21911 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each irie. Approximate Interval Between Onset and Death Imme late Cause (Final disease or condition resulting in death) Physician 69 Ischemic /Medical Due to (or as a consequence of): Examiner Myo cava Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit 144 Oronary and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a d be detached for P.O. 9 Unknown 9 ☐ Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1∐ Yes Certification: To this 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 □Yes 2 □No after death. 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a
To the Funeral D Hospital

3+IVA

State Registrar

completely

Medical

29a, Certifier

(Check only

29b. Signature and title of certific

30. Name and address of person who co

(Month, Day, Year) FEB 16 2

donia Way Juste Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0033925

29d. Datę signed (Month, Day, Year)

2010

Ruing SUN MD 21911

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 2010° Pauline Cosby 18:00P [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign (Month, Day, Year) 1956 | South Carolina 1 M 2 X F Days Director 53 250-04-0763 Yrs. Usual Residence of Decedent show 10a. State "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4807 King Fisher Court 20603 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 √ No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) hould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary Dept. of State Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o မ Unknown Elizabeth Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marquita Bennett/ Daughter BOOO Gallery Pl. <u>Apt. 36, Waldorf, MD. 20602</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Mem. Cemetery Feb.13, 2010 Waldorf, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ HENATIC ENC Du to (or as a consequence of): disease or condition resulting in death) ENCEPHALOPATHY FROM END STAGE LIVER Medical Examiner RENAL LEVATO Sexual ritinity list over title ins Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed SPONTANEOUS nding physician and ise as the burial-tran that initiated events resulting in death) Last Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No nours after death. neral Director: Aft If filled in by the fur ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sangerthal D0069835 2/5/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BB113 500 Forest Glen Rd Silver Spring Md. 20910 32. Pegistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deat Physician/ CONTEL OBERT 2 010 792 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 16502 Not<u>tingham Road</u> Prince George 8. Date of Birth Funeral Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F Days Months Min 2/26/191 Hours Country Director 577-26-2085 02 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No Maryland Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16502 Nottingham Rd USA 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Be Completed by 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Contee Rebecca William Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16502 Maragret E. Contee/Wife Nottingham Rd, Upper Marlboro MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Clinton Maryland 2/18/10 Signatur of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral HomePa, Aquasco MD 20608 01589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician. wo disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a solissiquence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of cert 29c. License number Name and address of person who cor ed cause of death (Item 23a) (Type, Print) MD 146 31. Date filed (M egistrar s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Bettie Jean Darnaby **Physician** 21:40 Felo 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince Georges Hospital Cheverly | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10/12/1954 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 55 577-76-7815 DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "matical Examination traumatic event, the "matical Examination to mathematical Examination to the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of th 28a-f shov MD 1 Yes 2 No Prince George's Hyattsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4405 73rd Ave 20784 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Government 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Thelo Lee Mooten Martha Downell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joyce D Brooks - Sister 4405 73rd Ave., Hyattsville MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 2/18/2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem Ceme Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityDL McLaughlin Funeral SE, Wash DC 20020 21. Signature of Funeral Service Licensee Home 2019 MLK Jr Ave 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease Physician oronam disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oexterks on Sequentially list conditions, if any leafur the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Ohes Morpig physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mon Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an 1 ☐ Yes 2 ☑ No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending ours arter death.

neral Director Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

Faren 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Brooks 3001 MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

00049183

Hospital Dr.

Cheverly

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and rtificate of Death		2010 05/96
			Registrar  1. Decedent's Name (First, Middle, Last)	runcate of Death	2. Date of Deat	eg. No.) = 0
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-rates	Medic Examin		Eula G. DeLaine  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl		4c. County of Death
	=xaiiii		Holy Cross Hospital	Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.		Birthplace (State or Foreign
	Director		151-16-6185 1 □ M 2 🖾 F 94 Yrs.	Willis Days Flours Will.	7/3/191	South Carolina
	bow at	ž	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
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	or 28	ä	MD Montgomery Silver  10e. Street and Number	10f. Zip Code		log, Citizen of What Country?
	with s 23a	Funeral Director	2505 Musgrove Road			USA
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פַ	filed \		17. Father's Name (First, Middle, Last)		ne (First, Middle, N	
<u>Vla</u>	d be Menta arked	잍	Willie C. Gerald	Unknow	n	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Maili	ng Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip Code)
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Baltimore,	ge 1 and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state		123 Bullar 2 - Olemation 0 - Nemovar nemotate	matory`or other place)		20c. Location - City or Town, State
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Box 687	eath certifica attending ph for use as th	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
ŏ	eath c	icia	in the past 12 months?  1 Ves 2 No.  1 Pregnant at time of death 5 [	Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Country  Co		Month Day Year
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ta	nysician: The nis certificate director, pag	m	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)	has =
<u>}</u>	Phys this a	12	1 ☐ Yes 2 🔀 No Hospital: 1 🔀 Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a, Date of injury 28b, Time o			nce 6 Other (Specify) w injury occurred
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Division of Vital Records,	tal or rs afte al Dir		building, etc. (Specify)		City or Town	, State)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death.  To the Funeral Director, Herr this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death (Check 2 ☐ Medical Examiner: On the basis of examination and/or invest			
	thin 2 the f the f mplet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and pla	ice, and due to the	cause(s) and manner as stated.
	<b>5</b> ≥ 5 8 ≤ 5		295. Signature and title of certifier	29c. License number	ŀ	9d. Date signed (Month, Day, Year)
	2 /		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D0066249		2/10/2010
2	4		Dr. Duran Holy Cross Hospital 500 Fo		lver Spr	ing. MD 20910-1484
	Stat	e	31. Date filed (Month, Day, Year)	TOBE OF THE ROAD DE	TICL DPL.	
	Registra	ır	FFA 1 6 2010 Deneus D. Market			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04P.M JACQUELINE ANDREA DUVALL Pebruary 2010 /Medical Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death 4b. City. Town. **Examiner** If Under 8. Date of Birth (Month, Day, Year) 06-11-1949 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min DC 212-54-4794 60 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hyglene. Internet of Health and Mertal Hyglene. Internet is a said of 28a-f show Important: If ferm 7 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Italia is reflected. 1X Yes 2 □ No Directo LaPlata Maryland | Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10200 LaPlata Road 20646 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11, Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify: White Specify: 3 ☐ Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Personnel Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Davis William A. Duvall, Jr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 331, Lively, Virginia 22507 William A. Duvall, III/brother Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 02-18-2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hedgman MO1374 Mary Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 50 vere disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the 9 Unknown eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has page 2 s certificate 1 □Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient ၉ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No n 24 hours after death.

The Funeral Director: A pletely filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier ical Medi and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of cerlifia 29c. License number

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State

Registrar

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lee Dunbar Feb 2010 2:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1110 Hamlin Road Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year, an 5,19 1 X M 2 - F 84 Months Days Hours Min **Director** 236 38 9277 WestVirginia Jan 1926 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Charles Waldorf 28a-f 1 X Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 5205 Tattler Court 20603 US items 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by ō 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event "to once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 8th Coal Miner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 20 Olif Spencer Dunbar Bertha May Workman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Weaver/daughter 5205 Tattler Ct. Waldorf, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Tabor Cemetery 2-17-10 Beckley, WVirginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington Rd Waldorf MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events plie to for as a consequence of burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be early hours after cleath.
24 hours after cleath.
Funeral Director: After this certificate has been signed by the attending physicia. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify 1 🗌 Yes 2 No Assist. 0 1 Inpatient 2 I ER/Outpatient 3 I DOA living funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

6003

State Registrar 6) ov

address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

DHMH 17 Rev 7/2009

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POST OFFICE RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State	of Maryland	-			Mental Hy	giene	010	0.7700
		1	State Registrar			Cer	tificate of l	Death		Reg. No.	<u>U I U</u>	02/99
	Physicia	./	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month	Day	Year	3. Time of Death
	Medic	al	MELVA POWE							/2010		1:30 P ^M
	Examin	er	4a. Facility Name (If not institution				•	r Location of Dea	ath		nty of Death	DOELC
			LARKIN CHASE  5. Social Security Number	NURSING H	OME 7. Age (In yrs. la	st hirthday)	BOW If Under 1 Year		s. 8. Date of Bir		GE GEO	lace (State or Foreign
	Funeral Director		231-01-1277	1 M 2 13tF	93	Yrs.	Months Days	Hours Mir		iy, Year) 1916	Court	land, VA
			Usual Residence of Decedent									
	/land f sho	햣	10a. State 10b. County	1	10c. City	, Town or Loc	ation				1	0d. Inside City Limits  1X Yes 2 □ No
	28a- notifie	ire		e George'	s Bow	rie	101 7: 0-1-				63411 1 6 0 1	
	th the	Funeral Director	10e. Street and Number	-			10f. Zip Code			10g. Citizen o		
	ath wi	nuel	2537 Ann Arbor		edent Ever in U.S	13. V	20716		Specify Yes or No-		d Stat	
2	or ite	by Fi	1 Never Married 2 Ma	Armed F		l I	Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)	В	lack, White,	etc.
Š	safte ral", Exar		3 XWidowed 4 ☐ Divorced	If Vec G	ive	1	☐ Yes 2 🔀 No	Specify:		Spec	ify: Blac	ck
ה ה	"natu dical	Completed	15. Decede	ent's Education est grade complete	d)	16a. Deced	lent's Usual Occup	oation during most of w	orking	16b. Kind of	Business In	dustry
7	hin 7% ne. than	E O	Elementary/Seconday (0-12)		1-4 or 5+)		O NOT use retired,		-			
7	d wit Hygie ther nt, th	Be C	12 17. Father's Name (First, Middle,	I ast)		Data	ı Analyst		lame (First, Middle		rnment	
<u> </u>	be file antal F ked o c eve	일	Joseph Powell	Zaoty					e Griffi			
<u> </u>	ould nd Me mari		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street		Rural Route Numb		, State, Zip (	Code)
Ĕ	12 shalth a		Jay Powell / N	ephew					Bowie, M			
e,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑XBurial 2 ☐ Cremation	4		lace of Dispo	sition (Name of natory or other pla		Date		on - City or To	
Ĕ	Page nent ant: It		4 ☐ Donation 5 ☐ Other	(Specify)	11 State	sevelt	Memoria	1 2/	13/2010	Chesar	eake	V.A
partituor	permit. Departr Import any inj		21. Signat of Funeral Service	Licer ee	~ 4 * * *	22	. Name and Addre	ess of FacilityPo	pe Funer	al Home	s, P.	A. and 20747
<u> </u>	g 0 = 4 0		- flugge	Hayer	2010						Maryl:	
			23a. Part 1. Enter the disease, shock, or heart failure. List	only one cause on o	caused the death each line.	n. Do not ente	er the mode of dyl	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	nysician/ Medical	6 9	Immediate Cause (Final disease or condition resulting in death)	a	RDIAC AF		IIA				-	011001 2112 202111
	Examiner		resulting in deathy	Due to	o (or as a consequ	ience of):					1	
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a consequ	uence of):						
	ited ansit	ä	cause. Enter Underlying Cause (Disease or iinjury that initiated events	•							- 3	
	execu an an rial-tr	dical Examiner	resulting in death) Last	Due to	o (or as a consequ	uence of):						
2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funderal Director: After this certificate has been signed by the attending physician and for the Funderal Director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dica		d								
200	rtifica ling pl e as t	Physician/Me	IF FEMALE:	230 If yes o	utcome of pregna	nev						
×	ith ce ittend or us	äi	23b. Was decedent pregnant in the past 12 months?	1 🔲 Liv	e Birth 2  Feta	al death 3	Ectopic pregnar Other (specify)	псу			Date of deliv Month	ery Day Year
POX	the a	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9 🗆 Un		Jean 52						
л Э	hat th ed by detac		Part II. Other significant condit	tions contributing to	death but not res	ulting in the u	ınderlying cause g	iven in Part I.	23e. Did	tobacco use co	ontribute to t	he cause of death?
S'	Jires t sign ld be	ed by	DEMENTIA						_ 1 □	Yes 2 N	o 3 🗆 Pro	bably 4 🔀 Unknown
Vital Records,	w requ	plet							24a. Was	s an 24 opsy	b. Were auto	psy findings available empletion of cause of
ခို	he lar	Completed							perl	formed?	death? 1 ☐ Yes	·
ē	ian: 1 ortifica ctor, p	Bec	25. Was case referred to medica examiner?					Place of Death (C	heck only one)			
5	hysic his ce	은	1 ☐ Yes 2 🔀 No		Inpatient 2		nt 3 🗆 DOA		g Home 5 Res			/)
Division of	ing P	ate:	27. Manner of Death 1 X Natural 5 □ Pend	ling -{Mo	e of injury onth, Day, Year)	28b. Time of injury	wo	ıryat rk? ∐Yes 2 □ No	28d. Describe	how injury occ	urred	
<u> </u>	death death stor: /	Certificate:	3 🔲 Suicide 6 🗆 Coule		ce of Injury - At ho	me. farm. str	eet, factory, office		28f. Location	(Street and Nu	mber or Rura	l Route Number,
Ĭ	lor A after Direct		4 🗌 Homicide deter	mined buil	ding, etc. (Specify	)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			wn, State)		
_	spita hours neral	Medical	29a. Certifier 1 X Certifyir	ng Physician: To the	best of my know	ledge, death	occured at the tim	e, date and place	e, and due to the o	ause(s) and ma	anner as state	ed.
	he Ho in 24 he Fu pleter	Med	(Check 2 ☐ Medical only one) 3 ☐ Certifyir	g Nurse Practione	r: To the best of m	n and/or inves y knowledge,	death occurred at t	he time, date and	place, and due to t	the cause(s) and	manner as s	ause(s) and manner stated. tated.
_	Vith Volume		29b. Signature and title of certifi				29c. Licen	se number		29d. Date sig	ned (Month,	Day, Year)
				/			15	1028		teb.	4,2	110
R	- 8		30. Name and address of person	n who completed ca		1 23a) (Type, I	Print)	AND C	te-23	1 Ann	1 mm/10	MA. DUM
	Sta	te.	31. Date filed (Month, Day, Year)	1 202	Registrar's Signa	ture	gery.	TIVE D	1000	* 73744	pour	140 0140
	Registr		FFR 1 6 2010	Devera	D. A.	are						

Adrien Etsague Tohambon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Adrien Christian Etsague Tchambou Physician/ Month Day February 15, 2010 1331 hrs Medical Examiner <del>Tchambou</del> Etsaque 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale 4 Philadelphia Court Room 512 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Country) Cameroon Min Months Davs Hours 6/13/1973 36 none Director 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Middle River Baltimore 28a-f show MD the Maryland 10f. Zip Code 10g. Citizen of What Country? s 23a or 28a-f 10e. Street and Number 21220 Cameroon 9804 Decatur Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? within 72 hours after death 1 Never Married 2 Married Yes Black "natural", or Specify. Yes 2 X No specify: f Yes, Give Yea or Dates: 4 Divorced 3 Widowed ⋛ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Computer Technician Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than the Medical Pages I and 2 should be filed within timent of Health and Mental Hygene.

'tant: If item 27 is marked other that or other traumatic event, the Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Noelle Guedio Be Jean Tsaque 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co2 1) 1 5 5 19a. Informant's Name/Relationship (Type, Print ) ဥ 6800 Hollow Glen Court Gainesville, VA. Carine Azangue/Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 3/06/2010 Bafou, Cameroon Family Cemetery 4 Donation 5 Other Specify 21. Single of Funeral Service 29 HTT Land poddress of 38 WALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md2091 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List nly one cause on each line Death /Medical Acute salicylate and alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XUNPENDED  $^{\text{AMENDED}}_{\#}1,23a,27,28a-f,\text{per ME g901 }3/11/10 \text{ TT}$ attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Month Year 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available has been si 2 should b 24a. Was an prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 🗸 Yes 2 No page 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient DOA ER/Outpatient 3 2 this 1 V Yes No 28d. Describe how injury occurred subject ingested drug and 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 Yes 2X No Natural 1 5 Pending hours after death. Director: d in by the alcohol Fd 2/15/10 lunk 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc ed in by 3 X Suicide Could not be or Town, State) Philadelphia Ct. Rosedale, hotel the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier 2-PEND O.C.M.E. February 16, 2010

State 31. Date filed (Month, Day Year)
Registrar FEB 2 2 2010

DHMH 17 Rev 1/2001

**OCME 2006** 

Laron Locke MD.

ORIGINAL

areas

111 Penn Street, Baltimore, MD 21201

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

2. Registrar's Signature

10-01218

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Carl Eller		I- For State Registrar	Sta	ate of Maryla		artment of <i>rtificate of</i>		nd Ment		Reg. No.	201	0 05	801
Physicia	n/	Decedent's Name	, ,	. ,					Date of De Month	Day	Year	3. Time of De 1045 hrs	
Medical Examin		Carl Ho		11er	mbar)	· 1.	4b. City, Town, o	or Location o	February		010 c. County of De		· 
		Harford Mer		. 5	iliber)		Havre de C		, pour		Harford		
Funeral Director		5, Social Security N 238-34-5	852	6. Sex	7. Age (In yrs.	last birthday) 82 Yrs	If Under 1 Ye Months Da				For	Birthplace (State oreign Country) NC	or
any	}	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Locat	ion					10d. Inside C	ity Limits
<b>.</b> .	۱	MD	Ceci	1	С	olora						1 Yes	2 X No
Maryla 28a-f d at or	ect Ct	10e. Street and Nu	mber			-	10f. Zip Code			10g. Cit	izen of What C	ountry?	
th the Maryland 23a or 28a-f she notified at once	١	10 Wines	ap Ct.				2191			US		o de la diaz Ola	al.
	Funeral Director	11. Marital Status  1 Never Marrie  3 Widowed		A 1 5	2 No			an, Mexican,	in? ( Specify Yes or N Puerto Rican, etc.)	10-	White, etc		ick,
urs aft itural" amine	좕			or Dates: cify only highest grad			nt's Usual Occupa	ation (Give l	kind of work done	16b.	Kind of Busine	Thite ss/Industry	
5-0036 led within 72 hours a tygiene. other than "natura the Medical Examit	Completed	Elementary/Seco	ondary (0-12)	College (1	-4 or 5+)		ost of working life		use retired)				
withir siene.	<b>E</b>	17, Father's Name	/Eirst Middle	Last)		Tree	Surgeor		s Name (First, Middle		rees		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ceevent, the Medics	Bec	Andy E1		Lasty					Perry	, maidon	ourname,		
21,2 nould b d Men is mar	إع	19a. Informant's Na		hip (Type, Print)		19b. Mailing	g Address (Stre		ber or Rural Route No	ımber, C	ity or Town, St	tate, Zip Code)	
and 2 short ealth and cent 27 is:	1	Wilma Ko 20a. Method of Dis		daughter	1206		nesap Ct		lora, MD 2			or Town, State	
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traums	Н	1 $X$ Burial 2		3 Removal fro		crematory or other		emetery,			·		
Itim ii. Pag urtment ortant	-	4 Donation 5 21. Signature of Fu			Br	ookview	Cemeter	ss of Facility	2/16/2010			Sun, MD	
Dept.	-	Kuch	and	S. Ch	notie	111 ر	1 S. Oue	en St	ral Home, . Rising S	Sun.	MD 219	11	
Physician		23a. Part I. Enter th failure. List on	ne disease, or ly one cause	complications that co	aused the death	n. Do not enter t	he mode of dying	, such as ca	ardiac or respiratory a	rrest, sh	ock, or heart	Approximate Between Or	nset and
Examiner		Immediate Cause ( or condition resulting		a. Complication								Dear	th
	Jer	Sequentially list co if any, leading to in couse. Enter Under	nmediate	b. Due to (or as a	consequence	of):							
ted I nsit	Examine	(Disease or injury t events resulting in	hat initiated	Due to (or as a	consequence	of):							
tO,  e be executed ysician and burial - transit	edical	UNPENDED		AMENDED									
Division of Vital Records, P.O. Box 6876( no the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	ΣΙ	IF FEMALE: 23b. Was decedent past 12 months  1 Yes 2 I	?	ne 1 Live b	ant at time of d	2 Fe	etal death 3 ther (Specify)	Ectopic	pregnancy	23	ld, Date of deliving Month		'ear
that the	E P	Part II. Other signi				resulting in the u	underlying cause	given in Pa				e to the cause of de Probably 4 🗸 Ur	
IS, P.C quires that en signed	ted	emphysem	ia, lung ma	ass (clinical hist	ory)				24a. Wa			autopsy findings	
cords, law requir has been s	Completed				···	<del></del>			auto	opsy orm <u>ed</u> ?	prior death	to completion of can?	ause of
ital Recician: The sector, page	ខ្ញ	25. Was case refer	red to medical				26 Plac	e of Death (	1 Yes	2N	1 🗸	Yes 2	No
Vital ysician his cert directo	Be	examiner?	2 No	[Hospital:	npatient 2	ER/Outpatient		-Other -	Nursing Home 5	Reside	ence 6 Ot	ther:	
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Sion ttendi death. ctor:	誤	1 ✓ Natural 2 Accident	5 Pend Inves	stigation				Yes 2				D. I.B. A. N	b 0'h
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the our after death.  Ireral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 4 Homicide		d not be rmined 28e. Plac (Specify)	e of Injury - At h	nome, farm, stre	et, factory, office	building, etc	or Town,		and Number or	Rural Route Num	ber, City
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 2			of examination				ce, and due to the car curred at the time, dat				
E 3 F 3	ž	29b. Signature and	title of certifie					se number				Month, Day, Year)	
		M	la Bi	anil ME	>		0.0	.M.E.		Feb	oruary 12, 2	2010 	
HtIVA		30. Name and addr Melissa Bra	111	who completed cause Assistant Me			Penn Street,	Baltimore	e, MD 21201				
Sta	ate	31. Date filed (4)			egistrar's Signa				<del></del>				
Regist	rar	FE	n 103	OR Bus	m p	pas	<u> </u>	_					
DHMH 17 Rev 1/20	01		OCME			ÖRIGINA	ıL.						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 February 4:10 A Regina Frankl Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1801 E. Jefferson Street, Apt 205 Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year)1913 1 □ M 2 🖾 F Months Days Hours May 29 96 Yrs Director 099-18-6062 Austria Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County Director 1 Yes 2 No Rockville Maryland Montgomery 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? þe th and Mental Hygiene. 27 is marked other than "natural", or items 23a i traumatic event, the Medical Examiner must be Funeral 1801 E. Jefferson Street, Apt 205 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. by 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental rtant, If item 27 is marked o ဂ္ Nathan Wolfinger Bertha Fantner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Frankl/daughter 728 Easley Street Silver Spring, Maryland 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any Injury or o 1 Burial 2 Tremation 3 Removal from State Final Journey Crematory 2/15/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licer M00957 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 🔀 No sate has been signed by the page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Vnknown Advanced Alzheimer's Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 🗌 Yes 2 🗎 No certificate Yes 2 X No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 Natural work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year)

State Registrar

E

1801 E.

32 Registrar's Signature

R172412

Jefferson Street Rockville, Maryland 20852

211512010

aymoum one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2010

C.R.N.P.

Alyson Timlin,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0116 M February 12 2010 Wendy Lynn Fugitt 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1 □ M 2 🔀 F 49 2/12/1961 218-80-7014 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2 No Halethorpe | 10f. Zip Code Baltimore 10g. Citizen of What Country? 10e. Street and Number 241 Green Fern Way 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 | Yes 2 | If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 □Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Pet Product Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Evelyn Eldredge Richard Fugitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Fugitt - Father 5049 N. Hwy. Ala Apt. 1805 Ft. Pierce, FL 34949 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funefal Service Livensee roll M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hemmorhae rours disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last amy loidosis rimary Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of autopsy performed death? 1**¥**2Yes 2 □ No 1⊠Yes 2□No 26. Place of Death (Check only one) Hospital:

**Physician** /Medical Examiner

Department of Health and Mental Hygie Important: If Item 27 is marked other I any Injury or other traumatic event, III

**Physician** 

/Medical

Director

Funeral

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Completed

Be

MD

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medical Examiner must be restilled at

filed within 72 hours after death with the

Maryland 21215-0036

Baltimore,

Pages 1

death certificate be executed

Box 68760.

P.0.

Division of Vital Records, Fugitt, Wendy

Hospital or Attending

within 2.

Examiner

and burialattending physician Physician/Medical the the page 2 should Completed has certificate Be Certification: To

29a, Certifier

funeral director, After this death. 24 hours after death Puneral Director: completely filled in by the

> State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

BUILL M.

32. Registrar's Signature

recur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Cator Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05804 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day В. <u>Jessie</u> Graves February 2010 2307 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days (Month, Day, Year) Months Hours Min. Director 579-46-7143 83 1926 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No PG Upper Marlboro MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12603 Westover Court 20772 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Recreation Director DC Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walker II Arthur <u> Marie Kenner</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12603 Westover Court 1 and 2 s of Health item 27 Milton Graves Sr/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Date 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Removal from State 2/19/10 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery Md Laurel, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. | art/ . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, block, or heart failure. List only one cause on  $\neq$  c) line. Between nd Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ar as a consequence of **Examiner** Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Examine Due f for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year page 2 should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 \(\subseteq\) No 2 - No 1 Tes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yeş Other: 2 No ER/Outpatient 3 DOA 1 Inpatient 2 🗹 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Director; After Natural Hospital or Attending 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Pria Suite 101a filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

Division of Vital

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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1	İ	30. Name and address of person who	completed cause of death (Ite	m 23a) (Tvne	Print)					-//	<u> </u>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 5:30 A M Theresa W. Gaskins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 01ney Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days 1 M 2 X F 88 0870471921 Virginia Director 577-24-7812 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Montgomery 1 X Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 3700 International Dr. Apt 329 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 Yes : 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Defense Procurement Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H 7 is marked of မ <u>Eva Mae Bowler</u> <u> John Henry Wells</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 9511 Ocala St. Silver Spring, MD 20901 Jeffrey Gaskins / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🕱 Cremation 3 🗎 Removal from State cemetery, crematory or other place) Fort Lincoln 2/5/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. ancis Brentwood, MD. 20722 23a. r art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Ser 875 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No certificate has been signed by the a irector, page 2 should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, It is the funeral director, It is a second tilled in by the funeral director, It is a second tilled in by the funeral director, It is a second tilled in by the funeral director, It is a second tilled in by the funeral director, It is a second tilled in by the funeral director, It is a second tilled in by the funeral director, It is a second tilled in by the funeral director, It is a second tilled in by the funeral director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d, Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

18101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

LOVENDO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04, 2010 21:29 SAMUEL GARVIN. Sr. February V. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours 572171936 Allendale, SC Director 73 249-52-0850 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Prince George's Suitland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6011 Lucente Ave 20746 UNited States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Black "natural" 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ms College (1-4 or 5+) Elementary/Seconday (0-12) <u>Mechine Technician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Queen Ethel Washington William Garvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Garvin / Wife Suitland, Maryland Lucente Ave. 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 2/18/2010 Cheltenham, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service License M01085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician Acute Atheroscievotic Cardiovaccular diseas Medical resulting in death) Due to (or as a consequence of): Examiner unknuwn Pulmonary Embrism Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): hnknowy. Atria Hospital or Attending Physician: The law requires that the death certificate be executed Rapid FIDN been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENCION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 1 ☐ Yes 🎾 No 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director, 26. Place of Death (Check only one) Be Hospital ၉ 1 Inpatient 2 NOutpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Watural iniury 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D50689. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK MAIAAAN MD SUYTHERN MARLAND 7503 SHIZRATTES RIAD CLINTUNMD Latig20+ PEB 1 6 2010 32. Register's Signature State ark

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Deredent's Name (First, Middle, Last) ARDINER 238 M Year Physician/ REW Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Heart Homes Assisted Living Annapolis 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Days 1 M 2 □ F Hours Min. (Month, Day, Year) 5/4/1929 Washington, DC 80 Director 578-36-4138 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland innert of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 🖾 Yes 2 🗌 No St. George's Island St. Mary's MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20674 U.S.A. 45956 Shanty Point Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 □ No Army Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 X Divorced Year or Dates. 1951-56 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Blue Cross Blue Shield Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy C. Deckner Andrew Mitchell Gardiner, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 307 Cedar Avenue, Edgewater, MD 21037 Andrew Mitchell Gardiner, III permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Alexandria, Virginia 2/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury **To the Hospital or Attending Physic**ian: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 🗀 Fetal death Ectopic pregnancy in the past 12 months? Day for 5 Other (specify) Pregnant at time of death 2 🗌 No the a 9 Unknown ed by t s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has l page 2 s Yes 1 🗌 Yes certificate ON THEA **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) PRUMPE examiner? Other: FEART 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ပ္ ther (Specify) after death.

Director: After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 28a. Date of injury 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) FEB 1 6 2010

Name and address of person who comp

29b. Signature and title of certifier

NA WU 445 32. Registr 's Sign

ered cause of death (Item 23a) (Type, Print)

IUW

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DEFENSE HIGHWAY

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001

Registrar

FEB 12 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ 2010 Year 6, Goodrich 1445 Dorothy Marshall Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb 9, 1923 9. Birthplace (State or Foreign Country) New York **Funeral** Hours Months Days 1 M 2 XF Director 86 097-12-3020 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔯 No Maryland Montgomery Olney 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 1905 Bishops Castle Drive United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner ı 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married à 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) CEO Food Distributation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lawrence James Marshall Caroline Anaa Herr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Goodrich Pearce/daughter 1905 Bishops Castle Drive Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 2/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 homas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part t) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EFFUSZON Physician/ DLEVRAL disease or condition resulting in death) 20 01 45 Medical Due to (or as a consequence of): Examiner HEMORRHAGEC ENFAMMATORY PLEURETES 1-0 200445 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, The law requires that the death certificate be executed Cause (Disease or liniury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
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To the Funeral Director: After t (Month, Day, Year) 1 X Natural work? 1 D Yes 2 D No 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed The defice of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) eq 1. mil. wo 0 23630 FEBRUARY 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16220 FREDERICK ROAD #213 GALTHERSBURG, MARYLAND 20877

State Registrar 31. Date filed (Month, Day Year) FEB 1 6 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	State of Maryland / Department of Certificate o			jiene _{eg. No.} 201	0 05811
Dhuaisi		1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th Day Year	3. Time of Death 1:15 P M
Physicia /Medio	al	Eric N. Henry		1	29 2010	)
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea		8. Date of Birth (Month, Day	9. Bi	rthplace (State or Foreign country)
Director		214-60-5177 1 Months Day	/s Hours Mill.	5-20-1		maica
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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		DO0	64208		2-4-201	0
0.12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Saadia Husain, MD 4409 East-West Highway	Riverdale	. MD 207	737	
St.	ate	Saadia Husain, MD 4409 East-West Highway  31. Date filed (Month, Day, Year)  32. Registrate Signature	MINCIDATE	, 201		
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DHMH 17 Rev 1/2001

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Ing Paler	٦	<ul><li>27. Manner of Death</li><li>1 Natural</li></ul>	·		28a. Date (Mont) Jan 30	e of Injury h, Day Yea , 2010	r nr)	28b. Time of 1245 hrs	Injury	28c. Inj	-	Vork? → No				ury occurre by auto			
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Divi	ij	3 Suicide		d not be mined			-	d / Highwa		tory, office	Dullalli	g, ctc.	inte	or Town,	State) Shena	ındoah , \	VA	10000110	mbor, ony
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be extwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	2	4 Homicide  29a. Certifier 1 C	ertifving Ph	ysician:		<u>-</u>		ge, death occu		t the time, o	date an	d place, an	· · ·					ed.	
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St Regist	ate	31. Date filed (Month)	Day, Year)	1	*32. R	Registrar's	Signatu	ules											

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 2010 3:05 AM Alma L. Hill Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Min (Month, Day, Year) 05/08/1930 Months Davs Hours Country) Director 79 431-46-4204 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 ☐ No 28a-f MD Montgomery Silver Spring ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13120 Cabinwood Dr. 20904 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural" 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene, item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk NSA vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Grover Cleveland Lofton LaVenia King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13120 Cabinwood Dr. Silver Spring, MD 20904 Champ Stanley Hill/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) George Washington Cem 2/20/2010 Adelphi, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Coagulopathy Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical that the death certificate be Anemia Box 68760 as the t IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires is 24 hours after death.
 Funeral Director: After this certificate has been sign Division of Vital Records, Chronic Lymphocytic Leukemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been sit; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🏝 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ည 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D60826

Forest Glen Rd. Silver Spring, MD 20910

2/12/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0650 HAUSER FEBRUARY 4, 2010 WILSON HAZEL. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE PRINCE GEORGE HOSPITAL CHEVERLY If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 F Days Hours NORTH CAROLINA 241-36-2298 83 12-27-1926 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show important: If Item 27 is marked other than "natural", or items 1 by multiled at once.

and injury or other traumatic event, the Medical Experience must by multiled at once. 1 X Yes 2 No Director WINSTON SALEM NC FORSYTH death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 27105 U.S.A. 1930 EAST 18th STREET Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 📉 No Specify. BLACK Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT TEACHER 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LESTER H. WILSON MILLIE EGGELTON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10607 TERRAPIN HILLS CT MITCHELLVILLE, MD 20721 SIGRID H. SAMUEL/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State **EVERGREEN CEMETERY** 2-12-2010 WINSTON SALEM, NC 4 Donation 5 Dother (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or es a consequence of) physician sthe burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) signed by the a 1 ☐Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>8</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of Arteru 24a. Was an page 2 s oronacy 2 No 2 X No 1 ☐ Yes certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death After t Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 124 hours after death.

Reference of prector: A setely filled in by the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the fulled in the 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) **FEB 1 6** 2010

Cheverly, MD 20785

who completed cause of reath (Item 23a) (Type, Print)

32. Registrar's Signatur

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State

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIWA VEPUM 7525 Greenway Center Drive, Greenhelt, MD 20770

31. Date filed (Month, Day, Year)

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29c. License number

29d. Date signed (Month, Day, Year)

February 15,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 For State Registrar #29c, per physicians, 2/12/16 ertificate of Death E.T, WCHD Amended item 2. Date of Death 1. Decedent's Name (First, Middle, Last, Day **Physician** 2010 1645 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balin Worcests enl DOES THE DOD THE LAND Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 2/7/1914 7. Age **Funeral** Months Days Hours 1 □ M 2 🛛 F 216-40-4701 95 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 XYes 2 No Director Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or USA 211 N. Main St. 21811 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo Specify þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If item 27 is marked other that any injury or other traumatic event, Ina. once. Beautician Cosmetology 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Levin Melson Elizabeth Hudson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8611 Saddle Creek Dr., Berlin, MD 21811 Gloria Esham / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State 2/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Buckingham Cemetery Berlin, MD 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 108 William St., 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on fach line. Approximate Interval Betweer Onset and Death Hopetensi Immediate Cause (Final disease or condition resulting in death) (woldom-**Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to infinite indecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, the attending physician ned for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown ঠ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the License number D0050826 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State Registrar completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 240 2010 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 1 Year If Under 24 LL-Days LL-3 Ndel LOCK Birthplace (State or Foreign Country) 7. Age (In yrs. Id Date of Birth (Month, Day, Year) Social Security Number 6. Sex Months 1 **34**M 2 □ F 1950 213-48-2123 59 Aug 3, Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Anne Arundel Shady Side 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20764 1177 Grove Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American I Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Richard Carl Harris Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shady Side, Maryland 20764 Coleen Ann Harris/wife 1177 Grove Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 2/15/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 uanita Approximate Interval Between Onset and Death 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Immediate Cause (Final r1000 disease or condition resulting in death) 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or s a consequence of) Due to (or as a consequence of): yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Year Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

permit. Pages 1
Department of H
Important; if Ite
any Injury or ot

**Physician** 

/Medical

Examiner

10a. State

Director

by Funeral

Completed

Be

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**Funeral** 

Director

28a-f show ns 23a or 28a-f show must be notified at

Items 23a

'natural", or

the Medical E

f Health and Mental Hygiene. Item 27 Is marked other thar

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner by Physician/Medical Completed Certification: To Be filled in by

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

3 ☐ Suicide

4 Homicide

(Check only one)

24a. Was an autopsy performed? Yes 2 2 00 1□ Yes 26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ★ Yes 2 No Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 1 Natural
2 Accident 5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

eputy

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

leted cause of death (Item 23a) (Type, Print)

185, m

Year)

State Registrar

Medical

Registrar

10

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Frint)

32. Registrar's Signature

John E. McKnight, M.D.

31. Date filed (Month, Day, Year)

106 Irving St, NW Suite 2200N, Washington, DC

State

21585 Peabody St. Leonardtown,

MD

20650

cause of death (Item 28a) (Type, Print)

32. Redistrar's Signature

Jarboe,

Year

MD

James

31. Date filed /M

			For State	State of Ma	•		rtment of F				gien Reg. No	00	10	0.5	3221
			Registrar  1. Decedent's Name (First, Middle, Las	st)						2. Date of De		<u>-                                    </u>	I U	3. Time	of Death
	Physicia			chel		На	ith			Month Feb	1 1		Ye ar <b>0 1 0</b>	8:5	50a ^M
	/Medic		4a. Facility Name (If not institution, give			114	4b. City, Town, or	r Location o		100		. County o			
			2687 Kirk Driv	e			Waldor	f				Charl	les		u Pe
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	<i>hday)</i> Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Bir (Month, Da	a <i>y, Y</i> ea <i>r</i> ,		Cour	itry)	e or Foreign
	Director		218 53 1562 Usual Residence of Decedent	□ M 2□ <b>X</b>	1 1	TIS.				Oct 7	7,19	998 7	Alex	andr	ia,V
/land	A H		10a. State 10b. County		10c. City, Town	or Loc	ation						1	0d. Inside	City Limits
Man	ds J-e	ţċ	MD Charle	s	Walo	aor	f							¹ 🔀 Ye	s 2 No
th the	or 28	)ire	10e. Street and Number		7702		10f. Zip Code				10g. C	itizen of W	hat Cour	itry?	
ath wi	23a	<u>ra</u>	2687 Kirk Dri	ve			20603					US			
III 2 2 2 13-0030 be filed within 72 hours after death with the Marvland	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be retified at once.	by Funeral Director	11. Marital Status  ↑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 Th If Yes, Give Year or Dates:		If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Or an, Mexicar Specify:	n, Puerto R	ify Yes or No can, etc.)	D-		White,	-	
2 - C   2	n "nature Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)			Deced (Give I life. D	ent's Usual Occup kind of work done O NOT use retired	ation during mos	st of working		16b. l	Kind of Bus	siness/In	dustry	
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	d oth	Be (	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (	First, Middle	, Maide	n Surname	e)		
y a	I Men narke natic	၉	Rickey Haith							Forne	_				
<b>12</b> sh	th and 7 is not traum		19a. Informant's Name/Relationship ( Rickey Haith/				g Address <i>(Street</i> Kirk D				-			Code)	
an d	Heal tem 2 other	. 4	20a. Method of Disposition	racher			sition (Name of eatory or other place		Da			ocation - 0		wn, State	
Sages	ent of nt: If i		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.				rans Ce	i	2 25	2010	Ch	\0.1+c	nha	m 18/1	D
	oortar oortar rinjur		21. Signature of Funeral Service Licer		IND VE		Name and Addre	ss of Facili	ty BRT	-2010 SCOE-	. ТОN	ITC F	illia Illia	RAT.	HOME
	Depar Important ir		Samlell 180	LXOLION	UL 902		294 old								
			23a. Pa. 1. Enter the dise. e, or com suck, or heart fill te. List only	plications that caused one cause on each lir	the death. Do r	not ente	er the mode of dyir	ng, such as	cardiac or	respiratory a	arrest,			Approxim Interval E	letween
	nysician		Immediate Cause (Final disease or condition	a. Ca	nce	0	9	13	2~6	25				Onset an	a Death
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		je l	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of	of):							-		
uted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
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cate be executed	physician and the burial-transit	dical		<b></b> d											
> o	ding p	/Mec	IF FEMALE:	- 220 If you outcome	of prognancy										
The law requires that the death certif	has been signed by the attending I ie 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death		Ectopic pregnand  Other <i>(sp</i> ec <i>ify)</i> _	у				23d. Date Mor		ery Day	Year
s that	gned b	by Pł	Part II. Other significant conditions of	ontributing to death be	ut not resulting in	the un	derlying cause giv	en in Part I	l.	23e. Did	tobacco	use contri	ibute to t	he cause c	of death?
v requires t	en sig	edt								1 🗆	Yes 2	2 □ No	3 Prol	oably 4	<b>3</b> Unknown
aw F	as be	Completed								24a. Was		24b. V	Vere auto	psy finding	gs available f cause of
F He	cate h	5								perfe 1 □ Yes	ormed? 2 □ N	lo d	eath? □Yes	2 🗆 No	
V ILC	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.		Check only					
5 §	r this	l E	1 ☐ Yes 2 ☐ Io  27. Manner of Deat	1 ☐ Inpatie	nt 2 ER/Ou	tpatien	t 3 □ DOA Ott	4 L N		e 5 Res 3d. Describe				fy)	
	th. : After : funera	ţi	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		njury	Wor	ḱ?  Yes 2. □				,	-		
Affer	ector ector by the	iii	3 ☐ Suicide 6 ☐ Could not be determined		iry - At home, fai	rm, stre	et, factory, office		28	If. Location (	(Street a	and Number	er or Run	al Route N	umber,
<u>를</u> 2	rs afte ral Dir led in	Certification: To													
To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  Certifying Physical Example (Check only one)	nysiclan: To the best on miner: On the basis of and manner sta	f examination an	e, death d/or inv	occurred at the ti estigation, in my	me, date a opinion, de	nd place, a ath occurre	nd due to the d at the time	, date a	(s) and ma nd place, a	nner as a	stated. o the caus	e(s)
To th	within To th	Me	29b. Signature and title of certifier	7			29c. Licens	se number	· ( )		29d. D	ate signed	(Month,	Day, Year,	)
ST	gu		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, F	Print)	(Q	ol_	A	~ ^	1 1	111	CLIK	
۲.	7		31. Date filed (Month, Day, Year)	32 Registr	arls Signature			, (	re	. 1		1 0	06	40	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0582 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tiny Hancock February 7 - 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4785 Strauss Ave Indian Head Charles . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min. (Month, Day, Yea 1 🏻 M 2 🗆 F Months 577-14-5567 Director 89 Maryland Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland dartment of Heatht and Mental Hyglene. admirtent of Heatht and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4785 Strauss Ave. 20640 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 11 Marital Status Armed Forces? 1 Yes 2 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 😾 Widowed 4 🗆 Divorced Year or Dates. WWTT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Machinist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Budd Andrew Hancock Mary Elizabeth Cooksey 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Hancock 3910 Cindy Ct., Indian Head, permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t Md. 20b. Place of Disposition (Name of cemetery, crematory or other place Feb. 19, Date 2010 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, M00668 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part 1. Enter the di shock, or heart ail Immediate Cause (Final Approximate Interval Between Alzhermer Dementiq Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year þ Completed

Box 68760 Division of Vital Records, P.O. completed filled in by the funeral director, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this

Be

Medical Certificate: To

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 - 01111111111					
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
Phinator	Arthr.7	5		24a. Was an autopsy performed? 1 ☐ Yes 2 🗖 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
25. Was case referred to medical			26. Place of Death (Che	ck only one)	
examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🗈	lome 5 Residence 6	Other (Specify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			y, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
(Check 2 Medical Exam	sician: To the best of my know iner: Op the basis of examination se Practioner: To the best of my	n and/or investigation, in	my opinion, death occurred	at the time, date and place	, and due to the cause(s) and manner stated

D0033426

P.O.Box 2665 LaPlata MD. 20646

2010

6x State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Month} 9-20 10 Physician/ Earnest Johnson Sr 6:15PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton 8. Date of Birth (Month, Day, Year) 7 – 1 3 – 1 9 4 2 If Linder 1 Year If Linder 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 ₺ M 2 □ F 67 Director 224-54-4081 Pennsylvainia Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Μđ Prince George's Temple Hills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20748 2563 Iverson Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 tof Health and Mental Hygiene.
If item 27 is marked other than "ror other traumatic event, the Med Blue Cross Elementary/Seconday (0-12) 12 College (1-4 or 5+) Animal Groomer Animal Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jack Johnson Mary E Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2563 Iverson St Temple Hills Md 20748 Deloris Whitney Johnson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 듕 permit. Page 1 Department of Important: If it any injury or o ⊠ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 2-20-2010 Clinton, Maryland 4 ☐ Donation > ☐ Other (Specky) Resurrection Cem 21. Signature 22. Name and Address of Facility Ronald M Taylor 11 Funeral Home 10583 Middleport Ln White Plains Md 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one pause on each line ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ISTESTE Medical Examiner 13 C Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for selectneadyance of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death page 2 should be detached Unknowr g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d, Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Certifying Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D198 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar SouTher

132

MD

32. Registrar's Signature

BoTello

31. Date filed (Month, Day, Year FFR 1 6 2010

Months

3. Time of Death

1X Yes 2 No

Birthplace (State or Foreign Country)

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last) MARY D. KELLY

2. Date of Death 02-07-2010

8. Date of Birth (Month, Day, Year)

4b. City, Town, or Location of Death

Hours

Days

20743

6:45 AM

4a. Facility Name (If not institution, give street and number) 4114 Ellis Street

Capitol Heights If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)

89

4c. County of Death Prince George's

**Funeral** Director

23a or 2

Completed by

ဥ

Examine

Physician/Medical

Be Completed by

Pages 1 and 2 should be filed within 72 hours after death

of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

433-26-1442 Usual Residence of Decedent 10a State 10h County Director Maryland

10c City Town or Location

01-01-1921 10d. Inside City Limits

10e. Street and Number Funeral

Prince George's Capitol Heights 10f. Zip Code

10g. Citizen of What Country?

**IISA** 

4114 Ellis Street 11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:

College (1-4or 5+)

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 No Specify.

14 Bace - American Indian Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th

16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk

16b. Kind of Business/Industry Private Industry

17. Father's Name (First, Middle, Last)

1 M 2 TF

18. Mother's Name (First, Middle, Maiden Surname) Martha Christian

Walter Duncan

19a. Informant's Name/Relationship (Type. Print) Patricia Ina Kelly/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4114 Ellis Street, Capitol Heights, Maryland 20743

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

102-20-2010 Cedar Hill Cemetery 22. Name and Address of Facility

Suitland, Maryland

Hedgman Mo1374

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746

**Physician** /Medical Examiner

physician s the burial

**Hospital or Attending Physician**: The law requires that the death certificate be executed 24 hours after death.

Box 68760.

P.O.

Division of Vital Records.

permit. Pages
Department of I
Important: If it
any injury or o
once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

_ a	MYDERCAICEMIA
	Due to (or as a consequence of):
h	Renal Failure
D	Due to (or as a consequence of):
	DA H. 1 2M. 1

Due to (or as a consequence of):

Stage 11.

26. Place of Death (Check only one)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify).

23d. Date of delivery Month

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown

24a Was an 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death

3 Suicide

4 Homicide

1 Natural 5 Pending investigation 2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Certification: To 29a. Certifier Medical (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Reed Army

29b. Signature and title of certifier

30. Name and address of persol who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

10

reral Director: /

31. Date filed (Mo. Day, Year)

Oncology SVC Watter J. MARTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05824 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 13 2010 ROBERT THOMAS KLEINKNECHT 5:30 A M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. (Month, Day, Yea /01/1945 Country)
w Jersey **Director** 006-44-1081 64 New Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Florida Collier Naples 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34109 9178 Troon Lakes Drive U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? , or Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: Caucasian 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert C. Kleinknecht Dorothy Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maura Kleinknecht (Wife) 9178 Troon Lakes Drive Naples, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2/16/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 22. Name and Address of Facility Marshall's Funeral Home, Inc. . Signature of Funeral Service Licensee M0097 4217 9th Street, N.W. Washington, D.C. Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Bleedin disease or condition resulting in death) oaltroin testina Medical Due to (or as a consequence of): Examiner yeurs lanal cel Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a condequence of attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown à signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 □ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

Division of Vital Records, P.O. Box 68760

this certificate has within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Hospital

မ

Certificate:

Medical

2 **X**(Vic

5 Pending

Investigation 6 Could not be

determined

27. Manner of Death

Natural

4 Homicide

only one)

29b. Signature and title of certifier

29a. Certifier (Check

Accident Suicide

17397 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAITH R. ALTAWEEL 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year)
FEB 1 6 2010 State Registrar

1 Nonatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

2 🗌 No

28a. Date of injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05825 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 2010 MARJORIE C. KRAFT FEB. 4 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4004 BEECHWOOD RD PRINCE HYATTSVILLE GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 □ F Months Days Hours Min 144-22-5662 Director **JERSEY** 81 AUG. 6, 1928 NEW Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner must be rediffed at 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No PRINCE GEORGES HYATTSVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4004 BEECHWOOD RD. 20782 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. <u></u> Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important; If item 27 is marked other? any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILTON CHAMBERLAIN 2 CAROLINE WOOD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNEST R. KRAFT/HUSBAND 4004 BEECHWOOD RD., HYATTSVILLE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FEB.5,2010 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A rambers 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. DEMENTIA **YEARS** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADULT FAILURE TO THRIVE MONTHS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS and burial-tran Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending p for use as t IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown signed be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed page 2 should OSTEOPEROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 15\( \text{Nesidence} \) 1 Residence \( 6 \) Other (Specify) Medical Certification: To 1 ☐ Yes 2 😿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b, Signature and title of certifier Tot 29d. Date signed (Month, Day, Year) 29c. License number Cam, algorial D0067611 FEB. 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **CHEVONNE** SALMON, 6525 BELCREST RD., HYATTSVILLE, MD. M.D. 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Joseph A. Kempic 03:15 AM FEBUARY 08 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. STAGNES HOSPITAL 8. Date of Birth (Month, Day, Year 4-20-1931 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Days 1**⊠** M 2□ F Months 163-24-6668 78 PA **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Wedical Examiner is use by notified at Director 1 ☐ Yes 2 No Howard Ellicott City 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 9553 Westwood Dr. 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1949-If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White ۾ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Kempic Anna Halko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Kempic / Son 3125 Old Fence Rd., Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 2/11/2010 Ardent Cremation Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 3 rvice Licensee M0141122. Name and Address of Facility Harry H. Witzke's Family FA, Inc. 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEPATIC ENCEPHALOPATHY 10 DAYS /Medical resulting in death) Due to (or as a consequence of): Examiner YEARS CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed HEPATITIS EARS and Due to (or as a consequence of): signed by the attending physician Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, LYMPHOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 6 Could not be To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10069370 MEDICAL FEBRUARY DOCTOR 09 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) < x1 900 CATONS AVENUE 21229 KWAME NTIM BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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MAKER

Barke

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Fehra Charles Keith Kirby 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death p Center La narle If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 1ADM 2□ F Hours Davs Months 407-20-1979 December 31. 1925 Kentucky Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1X☐Yes 2☐No Maryland Charles Waldorf 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 3605 Forest View Drive **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 X1Yes 2 No If Yes, Give Year or Dates: Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Salesman Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe Bobo Kirby Lila Underwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 Forest View Drive, Waldorf, Maryland 20601 ace of Disposition (Name of Date 20c. Location - City or Town, State Mary Rainbolt/ Daughter 20a. Method of Disposition 1 IX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 □ Donation 5 □ Other (Specify) <u> Trinity Mem. Gardens :Feb. 16, 2010 Waldorf, Maryland</u> 21. Signature of Funeral Service L 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 MØ1190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ew minh Due to (or as a consequence of): DOZ GADI CORUMAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? heo Bronchitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☑ Unknown GBRI 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy BRONCHOSDASM 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Wedical Evandor must be notified at

Funeral Director

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Completed

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier

death with the Maryland

21215-0036

Maryland

Baltimore,

1 and 2 should be Health and Mental

Pages 1

Uepartment of Health and Ment, Important: If item 27 is marked any injury or other traumatic evonce.

attending physician

After after death

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital of within 24 hours a To the Funeral D

State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

te 306 Wa

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 92010 (= BRUMM 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Pate

6 ☐ Could not be

31. Date filed (Month, Day, Year) FEB 1 6 2010

and manner stated

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05828 Certificate of Death 2. Date of Death Month February 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Lebherz Jr 4:40 am ^M William Bennett 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Medical Examiner must be notified at Baltimore, Maryland 21215-0036

for State Registrar

**Physician** 

/Medical

Examiner

Funeral Director

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Country Meadows	Ketiremen	t Ctr	F	Frederick						rederick		
	5. Social Security Number 220–10–5346 6. Se	ex 7. Age	(In yrs. last birtho	Month:	er 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug 2.	ay, Year)	(	irthplace (Si Country) W Yor	tate or Foreign	
	Usual Residence of Decedent												
ctor	Maryland Frederi	ck	10c. City, Town o									de City Limits Yes 2 🛛 No	
al Dire	10e. Street and Number 5957 Quinn Orchan	rd Road		10f. 2	Cip Code	04		-	n of What C	-			
runer	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 □X/es 2 □ N	ver in U.S.	If Yes specify Cuhan Mexican Puerto Rican etc.)					ite, etc.	an,			
d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1946	46 Specify: Specify:							hite		
Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5- 5+	(6	ecedent's Us Give kind of v fe, DO NOT rketin	vork done d use retired	furing mosi ')	t of workir Ve	ng	i	factu			
o Be C	17. Father's Name (First, Middle, Last) William Benne		bherz	Sr		18. Mothe Hari	_	(First, Middle	, Maiden Su	urname) Behi	ney		
	19a. Informant's Name/Relationship (7 William B. Lebher:							1 Route Numb				21798	
	20a. Method of Disposition 1		20b. Place of D cometery, St John	isposition (N crematory of S Cet	ame of other place neter	y Fe		, 2010			or Town, Sta		
	21. Signatury of Funeral Service Licent	Beison		22. Name Kei 106 E.	eney ast C	& Basilit hurch	ford Str	P.A, eet, F	Funer	cal Ho ick, M	me Maryla	nd 21701	
	23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fisiture. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Metastatic Lung Carcinoma  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  1 1/2 years												
Examiner	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):												
edical		, d											
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										delivery Day	Year	
Dy P	Part II. Other significant conditions co	_	•		g cause giv	en in Part I					to the caus		
leted	Chronic Obstruct:	<u>tve Pulmon</u>	ary Dise	ase				24a. Was				4 Unknown	
Complete								auto perfi 1 □ Yes	psy ormed? 2XXNo	prior t death' 1 □ Ye	o completion?	n of cause of	
o Re	25. Was case referred to medical examiner?  1 ☐ Yes 2√√√No	Hospital:	nt 2 🗆 ER/Outp	ationt 3 🗆	Oth	or:		n <i>(Check only</i> me 5 ☐ Res		Cothe Ret	ireme	ent Ctr	
- 1	27. Manner of Death  ★★Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day		ne of	28c. Injur Worl		2	28d. Describe			osony)	4 50 50 50	
Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm . <i>(Specify)</i>	, street, facto	ory, office		2	28f. Location City or To	(Street and wn, State)	Number or	Rural Route	Number,	
dical (		ysician: To the best on niner: On the basis of and manner sta	examination and/									iuse(s)	
Ž	29b. Signature and title of certifier	mo at	tending pl	mysicus	29c. Licens DOO	90020	)			signed (Mo 23, 20	nth, Day, Ye 010	ear)	

Registrar

State

15

DIL

John A. Shutta, M.D., 15 East Frederick Street, Walkersville, Maryland 21793

pals

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**MAR 0 1 2010** 

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland	/ Department of H		2010	05020			
			Registrar  1. Decedent's Name (First, Middle, Las	et)	Certificate of		Reg. No.	3. Time of Death			
Н	Physici	an	D. I.I.A. MA	1	ZER	Mont	th Day Year	27			
	/Medic		4a. Facility Name (If not institution, give			r Location of Death	4c. County of De				
1	Examin	ier	50.0 A	11/1/5	ox Greenb		AG.				
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. las	t birthday) If Under 1 Year	If Under 24 Hrs. 8. Date	of Birth 9. Bi	irthplace (State or Foreign			
Н	Director		577847579 1	□M 284F 51	Yrs. Months Days	Hours Min. (Mon	th, Day, Year)	Country)			
	D.		Usual Residence of Decedent								
	nylan ihow	_	10a. State 10b. County	10c. City, 1	Town or Location			10d. Inside City Limits			
	e Ma la-f s	cto	MI) 1.6.	GR	een bell			1 DATes 2 □ No			
	or 28	Oire	10e. Street and Number	. #	10f. Zip Code		10g. Citizen of What C	*			
	23a	a	5909 CHERRYU		4 000	770	U.S.	· /			
	tems	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et	or No- 14. Race - Am tc.) Black, Wh				
36	s afte	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 1 1 1 No If Yes, Give Year or Dates:	1 ☐ Yes 2/1 No	Specify:	Specify: 2	Irall			
21215-0036	72 hours after death with the Maryland Inatural; or items 23s or 28s-f show disal Examinat he molified at	edt	15. Decedent's Ed		16a. Decedent's Usual Occup	pation	16b. Kind of Busines	s/Industry			
15	in 72 n "n	Completed	(Specify only highest gra	de completed)	(Give kind of work done life. DO NOT use retired	during most of working	1	·			
212	filed within Hygiene. other then "	om	Elementary/Secondary (0-12)	College (1-4or 5+) 2 415	Admin-	A35 T	Record.	5			
ğ	othe othe	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, A	Middle, Maiden Sumame)				
<u>a</u>	should be nd Mental marked c	To B	BOWARD J. A	ARKER		Mait E	Hertdersu	nl			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examinating the indifficult and page.	_	19a. Informant's Name/Relationship (	Type, Print) MUHLEN	19b. Mailing Address (Street	and Number or Rural Route	Number, City or Town, State,	Zip Code)			
	1 and 2 Health a em 27 is		MAITIE H.	LANKER 1	1427 Shad	Glen Dr	Copilo 11717	,			
Baltimore,	of He of He fitem		20a. Method of Disposition 1 □ Burial 2 1 Cremation 3 □	norm	ce of Disposition (Name of Interpolation)	Date	20c. Location - City of	or Town, State			
E	Pages nent of 8 int: ff ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	y) R1	rendala Pan	11 2/19/20	UN R.vendal	ind			
alti	permit. Pag Department Important: f any injury o		21. Signature of Funding Service Lice	100 M	22. Name and Addre	ss of Facility					
m	8 9 E 8 8		Xoyle y	Magen	5801 Cl	eveland Au	5 20	737			
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death.	Do not enter the mode of dyir	ng, such as cardiac or respira	tory arrest,	Approximate Interval Between			
	Physician [*]		Immediate Cause (Final disease or condition	ASCVA				Onset and Death			
	/Medical		resulting in death)	Due to (or as a consequer	nce of):						
	Examiner		Sequentially list conditions,	b							
	be sit	lne	Sequentially list conditions, a lary, leaving to finite eduction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a consequer	nce of):						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit				,						
687	ficate phys s the	Physician/Medical		_ Q,							
Вох	death certifica attending ph d for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc			23d. Date of d	elivery			
B	es that the death cer igned by the attendin be detached for use	clar	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal		Month Day Year					
0	the c by the	nys	9 Unknown	9□ Unknown							
٦.	s that ned b	γP	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the underlying cause giv	ven in Part I. 23e	. Did tobacco use contribute	to the cause of death?			
rds	w require been sig should b	pe pe	HTW STUD	Keng, CA	Obesity,	1	1 Yes 2 No 3	Probably 4 QUnknown			
Records,	law requ as been 2 shouk	olete	Asta	ma	(	24a		autopsy findings available			
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of Vital	ician: The lav certificate has rector, page 2	0	25. Was case referred to medical			26. Place of Death (Check	700 192110	20 20 10			
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 EF	NOutpatient 3 DOA Oth		Residence 6 Other (Sp	pecify)			
	ing Phys After this funeral di	L:u	27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Injury Wor	ry at 28d. Des	scribe how injury occurred				
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Division	or Attending ifter death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury · At hom building, etc. (Specify)	ation (Street and Number or a	Rural Route Number,					
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	To the Hospital or/Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier Certifying Ph (Check only one) 25 Medical Exar	nysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the ti n and/or investigation, in my c	me, date and place, and due ppinion, death occurred at the	to the cause(s) and manner time, date and place, and d	as stated. ue to the cause(s)			
	thin 2 the	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	29d. Date signed (Mo	nth, Day, Year)			
	F M F 8		b ( V/m	2111		3988		2010			
			30. Name and address of person who	completed cause of death (from 2		100	1171	auru			
1	4		Pat p c in	O' HORA	6325 Belchest	Ad 20752					
	Sta	ıtè	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	13 4 17 15 V . II	cino .					
	Registi		FFR 1 8 2010	Deneur B. A.	arke						

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 2010 J. Lambert Pau1 261 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6124 85th Place New Carrollton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-29-1932 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **½** M 2□ F Days Months Hours Rochester, NH 003-22-9717 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 20784 6124 85th Place United States 12. Was Decedent Ever in U.S. Argued Forces? 1 ☑Wes 2 ☐ No 1952— If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Gov't Plumber Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert J. Lambert Cecile M. Forcier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) West Minster, MD 21157 303 Denton Dr. Robert Martin ( POA ) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/15/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Brentwood, MD 20722 3401 Bladensburg Rd. Juli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ArteriosdersTic disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, reading to infine flats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence off Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? 1 □Yes 2 □ No 26. Place of Death (Check onl one) Other: 4 Nursing Home XX Residence 6 Other (Specify)

**Physician** /Medical Examiner

Department of Health Important: If item 27 any injury or other trong once.

**Physician** 

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be filled within 72 hours after in nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or itel
Inty or other traumatic event, I'm Medical Evan in it

Baltimore, Maryland 21215-0036

items

Director

Funeral

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Examine physician Physician/Medical ate has been signed by the attending page 2 should be detached for use as ğ Completed certificate Be

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To th within comp	Mo
CA-841	
Str	ate

24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1. Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year

31. Date filed (Month, 2010

Registrar

10-01335 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ronald Lawrence State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Month Day February 13, 2010 **Medical Examiner** 2348 hrs RONALD LAWRENCE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center 9. Birthplace (State or ForeignWEST Country) VIRGINIA 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 7. Age (In yrs. last birthday) Funeral Min. Months Davs Hours Director 39 APRIL 21, 1970 233-13-1727 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c, City, Town or Location 1 X Yes 2 No 28a-f show 27 is marked other than "natural", or Items 23a or 28a-f shov umatic event, the Medical Examiner must be notified at once. PRINCE GEORGE CAPITOL HEIGHTS MD 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 20743 U.S.A. 5620 PRESCOTT COURT Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 X Married 2 X No Yes BLACK Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after c
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", on injury or other traumatic event, the Medical Examiner m Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: è 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ted during most of working life. DO NOT use retired) College (1-4 or 5+) 3yrs Elementary/Secondary (0-12) Complei GOVERNMENT DISASTER SPECIALIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SANDRA LAWRENCE REGINALD RADFORD RHODES 19a. Informant's Name/Relationship (Type, Print) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 PRESCOTT COURT CAPITOL HEIGHTS, MD 20743 NEIKA A LAWRENCE/WIFE 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State LINCOLN CEMETERY 2-22-2010 BRENTWOOD, MD Donation 5 Other Specify: 21. Signature of Funeral Service License 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Medical Death Atherosclerotic cardiovascular disease complicated by Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) cocaine intoxication Sequentially list conditions if ally, leading to immediate Due to (or as a consequence of). Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a,27,28a-f,perm,E g902 4/27/10 TT XUNPENDED Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28b. Time of Injury After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2X No subject used drug 5 Pending Director: hours after death 2/13/2010 Fd 10:45 pm 2 X Accident Investigation 28f. Location (StreeLand Number or Rural Route Number, City or Jown, State) 5620 Prescott (t Capitol Heights, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be (Specify) found at residence determined within 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 . Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number February 14, 2010 OCME el 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) FEB 2 4 2010 32. Registrar's Signatu State

Registrar DHMH 17 Rev 1/2001 **OCME 2006** 

**ORIGINAL** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ethel S. Lantini 1:30  $P^{M}$ <u>February</u> 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2301 Old Frederick Road Catonsville Baltimore 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 □ M 2 F Days Hours Min (Month, Day, Year 2/01/192 Yrs. **Director** 215-14-4605 88 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits with the Maryland Director Examiner must be notified 1 Tes 2 No MD Baltimore Catonsville 0 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2301 Old Frederick Road United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married "natural", or 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Executive Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fishers is marked or ္ရ Cecil Evans Alma Wilkins permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony F. Lantini - son 18 Ridge Road Catonsville, MD other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 2/19/2010 Marriottsville, MD Crest Lawn Mem. Gdns. 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc Signature of Fuheral Service Licensee M00845 any Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MYOCARDIGL INFARCTION UTC te disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 25.29 ORONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy has certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tyes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other Specify) this 28a. Date of injury (Month, Day, Year) . Mannar of eath 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After injury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practioner T. the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner on stated (Check or brone 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar

State

gistrar's Signature

MELLA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 23 2010 2:55p HENRY PETERS MACATEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 220 Bay Circle Earleville Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 2 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. 199-16-1335 Director 1927Pennsylvania Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Bay Circle 21919 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. ģ 1 ☐ Never Married 2 🛣 Married 1 XYes 2 No Maryland 21215-003( 1 ☐ Yes 2 ☑ No Specify: and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", Specify: White 3 Widowed 4 Divorced WWII Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Television Elementary/Seconday (0-12) College (1-4 or 5+) Operator Sales & Service Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Bernard F. Macatee Catherine S. Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lee Macatee (wife) 220 Bay Circle Earleville, MD. 21919 Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If ite any injury or ot 1 Durial 2 Cremation 3 Removal from State 4 Dogation 5 Other (Specify) Kent Cremation 2/24/10 Smyrna, DE. 21. Signifure of Funeral Service Lice 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech M00510 118 West Cross st Galena. 21635 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Due to (or as a consequence of) pue Due to (or as a consequence of) resulting in death) Last bunialphysician Physician/Medical that the death certificate be Box 68760 the use as t attending plant for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death the 9 Unknown 9 Unknown P.O. | signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, The law requires 1 X Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2, No 1 Tyes Yes 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tyes 2 XNO ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No M Accident Investigation the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital

State Registrar

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifier

ria 31. Date filed (Month, Day

0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signatur

DIL

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amendatitem 18 per/fb G901 3/1/10 dk Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. Day 2010 **Physician** 20, 07:45 AM Paul Joseph Maniscarco /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Garrett County Mem'l Oakland Garrett Hospital 8. Date of Birth (Month, Day, Year) 01/05/1922 9. Birthplace (State or Foreign Country)
WV 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours Min. 88 235-20-0939 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Exampre must be notified at 1 Yes 2 □ No Director WV Tucker Thomas 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 60 N. Euclid Ave. 26292 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any finury or other traumatic event, I'm Maritim Exercise. 1 Never Married 2 Married 1 ☐ Yes 2X XNo Specify: Specify: White 2 3 X Widowed 4 ☐ Divorced Ye ar or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Coal Elementary/Secondary (0-12) 12 College (1-4or 5+) Coal Miner Strip Mines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RNXXXMXXXX Rosa Monda Anthony Maniscarco ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 368 Thomas, WV 26292 Ralph Maniscarco/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Thomas, 4 ☐ Donation 5 ☐ Other (Specify) 2/24/2010 21. Signature of Funeral Service Licensee ²²Hinkle Funeral Home, Inc. POBox 186 Davis, WV 26260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thin entiring Cause (Disease or injury that initiated events resulting in death) Last Due to (or 35 a consequence Examine ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, The law requires that the death certificate be Division of Vital Records,

Baltimore, Maryland 21215-0036

certificate has been signed by irector, page 2 should be detacl To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

> State Registrar

Medical

29a. Certifier

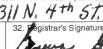
(Check only one)

29b. Signature and title of Certifier

Richard Porter. 31. Date filed (Month, Day, Year)

NAR 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated

Dakland, MD 21550

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

HDO64705

29d. Date signed (Month, Day, Year)

20 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 30 per DVR G901 3/1/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** LENA KOLU MOMOLU FEB.22,2010 10:05A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES

9. Birthplace (State or Foreign Country) 3263 WESTDALE COURT WALDORF 8. Date of Birth (Month, Day, Year) 8 - 9 - 1 9 4 2 Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2√2 F 67 Director LIBERIA NONE Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show ust be notified at 1 ☐ Yes 2 ☐ No Director MD. CHARLES WALDORF 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 3263 WESTDALE COURT 20601 LIBERIA or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? other treumatic event, the Medical Examiner: filed within 72 hours after ☐Yes 2 f Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ₩idowed 4 Divorced Year or Dates: "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry MINISTRY OF EDUC. nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) TEACHER LIBERIA 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fit and Mental F KORLOWUO MULBAH GAYDOU ENDOU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tree YAMAH ZAZA-DAUGHTER 3263 WESTDALE COURT WALDORF, MD. 20601 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) HERITAGE MEM.GARDENS 3-6-2010WALDORF, MD. 2. Name and Address of Facility 21. Signature of Funeral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Darrhord Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 6 Nuther (Specify) 2 5 Residence 28a. Date of Injury (Month, Day within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral curred 28d. Describe how injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: or Attending 1 Natural 2 Accident 5 Pending 1 Tyes 2 □ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

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Dr

State Registrar 0

31. Date filed (Month, Day, Year,

Krishan Mathur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\mathbf{D}_{\boldsymbol{X}}$ 

32. R

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gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ດ້72010 p M Evelyn Nall Mellinger 3:04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 8 Date of Birth 6 Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 6/24/1922 1 🗆 M 2 🖺 F Days Min. 87 Director 219-12-2649 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a6110 42nd Avenue 20781 U.S.A. filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates "natural", Specify. White Completed 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working marked other than matic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government/Clerical Inter-American Affairs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H 7 is marked o Page 1 and 2 should be Francis Marion Cornwell Winifred Nall Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health David D. Cornwell / Nephew 2499 Meredith Road, White Hall, MD 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2/20/2010 Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 RAM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MYOCAM DIAL INFARCTION. ACLITE Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit DIOGENIC Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of physician Physician/Medical Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. ours after death.

neral Director: A

filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 📴 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29d. Date signed (Month, Day, Year) 29b. Signature ar title of certifier 2 Amur 2/11/2010

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAWY SUMMIM, MD WAS HINGTON

WAS HINGTON ADVENTIST LASSO, TAKOMA PARK

Mario Monzon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day February 4, 2010 1410 hrs **Medical Examiner** Mario Monzon County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Camp Spring 6701 Coolridge Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Days Months Hours Director Country)Guatemala 1X M 2 F 09/20/1974 35 Yrs None Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10a. State 10b. County 1 Y Yes 2 No 28a-f show Md Prince George Camp Spring permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6701 Coolridge Rd. 20748 Guatemala Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced Yes, Give Year 1 X Yes 2 No specify: Guatemala Specify. Hispanic ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9th Labor Landscape 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) 11 K D Maria Silvestre Monzon Herrera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Federico Monzon/Cousin 30 Tunic Ave. Capitol Heights, Md. 20743 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 Removal from Sta General Cemetery 03/02/10 Guatemala 4 Donation 5 Other Specify Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Funeral Service Linens 3005 12th. St. NE Wash. D.C. 20017 et enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease or complications that caused the death. Do Physician failure. List only one cause on each line. een Onset and Mindinal Death Acute and chronic alcoholism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED X AMENDED by the attending physician ached for use as the burial 23a, PII, 27, 28a-f, per ME g903 5/20/10 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed b ģ 1 Yes 2 No 3 Probably 4 V Unknown Environmental Hypothermia Completed certificate has been sector, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other Scene DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes this ဥ 28b Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 Natural 1 Yes 2 XNo subject ingested alcohol Director: 5 Pending death. Fd 2/11/10 Fd 1406 hrs 2 X Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State 6701 Coolridge Rd 3 Suicide Could not be within 24 hours af To the Funeral D determined (Specify) residence 4 <u>Temple Hiľ</u> Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Lo and manner stated 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) February 12, 2010 O.C.M.E.

-Pens

Russell Alexander MD 31. Date filed (Month, Day, Year) State Registra

30 Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32 Registrar's Signature anka

Registrar

OCME 2006

State

30. Name and address of perso

31. Date filed (Month, Day, Year)

Jack Titus MD.

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111 Penn Street, Baltimore, MD 21201

erson who completed cause of death (Item 23a)

Deputy Chief Medical Examiner 1

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / D  1 - State Registrar	Certificate of De			No.2010	05839		
	Physicia	n	1. Decedent's Name (First, Middle, Last)  Roy Franklin Mills				Day Year	3. Time of Death		
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		February	ry 5, 2010   9:02 p [™] 4c. County of Death			
ا الس	Examin	er	Carroll Hospital Center		Westminster Carroll					
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		f Under 24 Hrs. 8 Hours Min. N	Date of Birth (Month, Day, Ye OV 29, 1	ear) Co	hplace (State or Foreign untry) Yland		
	e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State		stminster		10d. Inside City Limits 1 □Yes 2 No			
	th with the 23a or 28	Funeral Director	10e. Street end Number 2224 Snydersburg Road		21157		. Citizen of What Country? USA			
0036	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural" or items 23a or 28a-f show event, the Medical Evertines russ to puilted at	by Fune	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 □Yes 2♥ No	panic Origin? (Speci Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.		
712-0	thin 72 ho ie. an "natur Medical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupati (Give kind of work done dur life. DO NOT use retired)	ring most of working		b. Kind of Business/  Agricult			
ס	e filed al Hyg other	Be Con	17. Father's Name (First, Middle, Last)	Dairy Farmer	8. Mother's Name (			ure		
rylä	2 should be and Mental is marked aumatic ev	မ	Thomas Mills  19a. Informant's Name/Relationship (Type. Print)  19b.	Mailing Address (Street an			City or Town, State, 2	Zip Code)		
Ma	alth an 27 is er trau		Tina Mawhinney, daughter 2	224 Snydersbu	urg Road,	Westmin	ster, MD	21157		
ващттоге,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic es once.		20a. Method of Disposition  1 Burial 2 Acremation 3 Removal from State  4 Donation 5 Other (Specify)	Disposition (Name of horematory or other place)	02/12	/2010	c. Location - City or Winfield,	MD		
Balt	permit. Departr Importa any injt		21. Signature of Funeral Service Licensae	raw Funer ter, MD 2	raw Funeral Home Ler, MD 21157					
1	Physician		23a. Part). Enter the disease, or complications that caused the death. Do remock, or heart failure. List only one cause on each line.	not enter the mode of dying,	, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death		
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the	of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
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	xecuted and I-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequen							
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O. Box	death cer e attendin d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of de Month	olivery Day Year					
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Records,	ne law requires tl 9 has been signe ge 2 should be c	eted	south dang-hin Alzherner's type cellulihs both lead		utopsy findings available completion of cause of					
		Completed by				autopsy performe 1 □Yes 2	ed? death? KINo 1 □ Ye	completion of cause of s 2 □ No		
Vital	sician s certifi irector	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/O	Other	26. Place of Death		ice 6 □Other (Sp	ecify)		
on of	ing ing	Certification: To	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury hnjury Work?	at 2	8d. Describe how				
Division of	i or Attendi after death. Director: A d in by the fu	ertifica	3 ☐ Sulicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	2	8f. Location (Stre City or Town,		Rural Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledg 2  Medical Examiner: On the basis of examination at and manner stated.	e, death occurred at the tim nd/or investigation, in my op	ne, date and place, a pinion, death occurre	ed at the time, da	te and place, and di			
	To the vithir comp	Me	29b. Signature and title of certifier	29c. License			d. Date signed (Mor			
	WIL		the k Colem		1660		2/8/2019			
	311411		30. Name and address of person who completed cause of death (Item 23a)	CORNER MID.	su we	5 MINS	ier man	edad 21157		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 9 2010  32. Registrar's Signature	pare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Riddick Newland February Pay 2010^{ear} 11:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X**XM 2 □ F 90 1*1*72674919 Louisiana 439 56 7810 **Director** Usual Residence of Deceden 28a-f shor 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Washington DC XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1515 28th St NW 20007 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Naval Engineer US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Newland Kathleen Felix Riddick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 28th St NW/Washington DC 20007 Kathleen Newland/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Durial 2 X Cremation 3 Removal from State Metropolitan Crematory 02/19/201 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of suneral Service Licensee Advent Funeral & Cremation Services Falls Church VA and Annapolis MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Hypotension Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transit Cause (Disease or imjury Pneumonia that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Other (specify) Day Year Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown been si Completed 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law in 24 hours after death.
Funeral Director; After this certificate has b page 2 autopsy performed? Yes 2 X No prior to completion of cause of death? 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 XNo 1 Yes 1 Kinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 A Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending Accident Investigation M within 24 hours after death

To the Funeral Director, completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 65305 02/11/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila F. Khan, 1500 Forest Glen Rd., Silver Spring MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MARO Registrar

λο DHMH 17 Rev 7/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FEB. 2010 8:08 P M CLARENCE NEWELL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL ANNE ARUNDEL CENTER GLEN BURNIE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, SEPT 9 NEBRASKA Director 553-48-5998 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits must be notified at Director 1 Yes 2 □ No MONTGOMERY SILVER SPRING 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9039 SLIGO CREEK PARKWAY 20901 U.S.A. or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🔀 No Specify "natural", 3 x Widowed 4 ☐ Divorced Specify: Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ COLLEGE PROFESSOR UNIVERSITY OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ALBERT В. NEWELL ANNA Μ. BRANDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Department of Health Important: If item 27 any injury or other to once. STEPHEN A. NEWELL/SON 2039 HERMITAGE HILLS DR., GAMBRILLS, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY FEB.5,2010 RIVERDALE, MD. 21. Signature of Funeral Service Licensee FUNERAL HOME & CREMATORIUM, P.A prombende 20737 AVE., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) set and Death Houte .Pnysician/ Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to as a onsequence of: the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 L g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 WNo Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

1 Natural

2 Accident Accident

29a. Certifier

(Check

only one) 29b. Signature and title of certific

4 Homicide

5 Pending Investigation 6 Could not be

State Registrar

Medical

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) Gorbary mo Madyon 31. Date filed (Month

Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:03PM Frank Michael Notarangelo Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico S DUC If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth Funeral 1**X** M 2 □ F Days Hours Min. Feb. I Day, New Jersey 154-32-7748 Director Yrs Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified 1 ¥ Yes 2 □ No MD Worcester Berlin 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 400 William Street 21811 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ρ 1 Never Married 2 X Married "natural", or Yes 2 X No **3altimore, Maryland 21215-0036** If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify:White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene.
27 is marked other than '
traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation Contractor Carting Service Be Department of Health and Mental Hills Important if item 27 is marked of any injury or other traumatic and piece. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) くいいり Anthony T. Notarangelo Lillian Fasce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Meyer 400 William Street, Berlin, MD 21811 とって 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Cape Henlopen Crem. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb.8,2010 Frankford, DE 22. Name and Address of Facility ral Service Licensee The Burbage Funeral Home, netal 108 William Berlin, MD 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death PROSTA TR Physician/ MRTASTA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any heading to include cause. Enter Underlying Examiner Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burlal-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown Month Day Year 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 s has performed certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner'i Other: 4 Nursing Home 5 Residence Other (Specify) 2, No Hospital 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 📌 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 180 6 itavan WARY

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) FEB 12 2010

Registrar's Signatur

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	-	partment of He ertificate of D			201	0 05843
			Registrar  1. Decedent's Name (First, Middle, Last)		erimeate or b	Jean	2. Date of Deat	-	3. Time of Death
П	Physici		Virginia H. Nicoll				Month Februar	Day Year	
w.	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I		rebruar	4c. County of De	
	LAGIIII	CI	Wicomico Nursing Home		Salisbu	ırv		Wicomio	20
	Funeral	9	5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth	(Vear) 9. Bi	rthplace (State or Foreign
ь	Director		217-36-1943 1 1 M 2X F	101 Yrs.	Wioritis Days	TIOUIS WIII.	7/25/1	908	MD
	pu:		Usual Residence of Decedent  10a. State 10b. Counfy	10c. City, Town or	Location				10d. Inside City Limits
	laryla sho	5	MD Wicomico						1 □ Yes 2 □ No
	the N 28a-f	Director	10e. Street and Number	Salisb	10f. Zip Code		1	Og. Citizen of What C	Country?
	with a or	ä	707 Lakeside Dr.			0.01		ŭ .	outry.
	leath ns 23 mus	Funeral	11. Marital Status 12. Was Decedent B	Ever in U.S. 1	218 3. Was Decedent of His If Yes, specify Cubar		cify Yes or No-	USA 14. Race - Am	erican Indian,
	fter d r Iten iner	Fun	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ N	lo			Rićan, etc.)	Black, Wh	ite, etc.
ဗ္ဗ	urs a	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occupa ive kind of work done du e. DO NOT use retired)	tion uring most of worki	na	16b. Kind of Busines	s/Industry
2	rithin ne. han "	du l	Elementary/Secondary (0-12) College (1-4or 5-	+)				Health C	240
7	lled w lygie her t	Cor	17. Father's Name (First, Middle, Last)		urse	18. Mother's Name	(Firet Middle		are
and	l be f ntal H ed ot	Be	Charles Albert Holland				, , ,	maiden damame,	
Maryland	should be I and Mental   s marked o umatic eve	은	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street a	Abbie I		r. Citv or Town. State.	Zip Code)
	and 2 s ealth ar n 27 Is ner trau		Fred Nicoll / son		01 North Sh				
ē,	s 1 ar f Hea item		20a. Method of Disposition	20b. Place of Dis	sposition (Name of crematory or other place	, C. C. Kui,		20c. Location - City of	
Ë	Pages nent of Hant of Hant: If ite		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		nlopen Crem	1	/2010	Frankford	. DF
Baltimore,	<b>→ + + =</b>		21. Sinat of Fundal Service Licensee		22. Name and Address				
m	Depar Depar Impor any Ir		11. July 2 molas		108 Willia	m St., B	erlin, M	MD 21811	
п			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not e	enter the mode of dying	, such as cardiac o	r respiratory arr	rest,	Approximate Interval Between
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<u>is</u>	death death ctor: y the	icat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of inju	urv - At home, farm.	street, factory, office		28f. Location (S	treet and Number or	Rural Route Number
<u>\</u>	after Dire	Certification:	4 Homicide determined building, etc	c. (Specify)	•		City or Tow	n, State)	
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	he Ho n 24 he Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta		r investigation, in my op	oinion, death occurr	ed at the time, o	date and place, and d	ue to the cause(s)
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	Σ	29b. Signature and title of certifier	, 1	29c. License	number	2	29d. Date signed (Mo	nth, Day, Year)
	)		Mahaluri	118	0 6	05/5		2/11/10	)
	610		30. Name and address of person who completed cause of de		oe, Print) rn Shore Dr	ivo Col	isbury M	1D 21804	-
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DHMH 17 Rev 1/2001

VIRGINIA MIGOLL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 5844 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Februare Physician/ Bonita Marie Owens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min. Month, Day, Year Dec. 18 Wash 214 68 8264 53 1956 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 275 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Ves 2 No MD Charles Waldorf 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2336 Alava Court 20603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Consultant <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Claiborne Pinkney Evelyn Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2336 Alava Ct. Waldorf, Md 20603 Lisa Russell/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Riverdale Crematory 2-18-2010 Riverdale, 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses 2294 Old Washington Rd Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNKNOWN Physician disease or condition resulting in death) Medical s a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter or derrying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No hin 24 hours after death.

the Funeral Director; After this certific

mpleted filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a ollock MO

State

DHMH 17 Rev 7/2009

Registrar

30. Name and

GOOG

ryland 20706

ddress of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

Course

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02-08-2010 **Physician** 11:35 A M CORINNE F. PROCTOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bowie Prince George's Cureton Assisted Living 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year 1 ☐ M 2 ☐ YF Months Days Hours Min. 237-52-9409 74 05-13-1935 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience must be notified at 1X Yes 2 No Directo Marvland Prince George's Upper Marlboro the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13720 Captain Marbury Lane 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🎛 No If Yes, Give Year or Dates: Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Management Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William A. Hennessee Victoria Erwin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Dickerson/daughter 13720 Captain Marbury Lane, Upper Marlboro, MD 20772 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 2/19/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hedgman M0/374 Mary Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Malignant Neoplasm Bronchus and Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it among the cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month signed by the aid be detached for 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown s been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform After this certificate funeral director, page 2 **M**No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify Assisted 1☐ Yes 2☐No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation spital or Attendii nours after death. neral Director: A riilled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital within 24 hours a To the Funeral I

P.O. Box 68760,

Division of Vital Records,

Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) State 1 6 2010

29a. Certifier

29b. Signature and title of certific

JONA LESKUSKI

200 BasilCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1200000

29d. Date signed (Month, Day, Year)

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Ragistrar	State of Ma	aryland / De _l	partment of Fertificate of			ene g. N2 0 1 0	05846
			Decedent's Name (First, Middle, Last)					2. Date of Death	9.11822 0 1 0	3. Time of Death
	Physici		Rachel D. Pollock					Month 02	Day Year 05 2010	2:21 A M
-	/Medio Examin		4a. Facility Name (If not institution, give :			4b. City, Town, o	or Location of Death	1 1	4c. County of Dea	
	LAGIIII	ICI	Prince George's Ho	snital		Chever1	V		Prince Ge	enrees
	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
п	Director		263-70-2800	M 2131F	88 Yrs.	Months Days	Hours Min.	10/24/1	921	FL
	Ð ,		Usual Residence of Decedent  10a, State 10b, County		ton City Town as	1				10d todd Civilinia
	shov	_	Toa. State Tob. County		10c. City, Town or	Location				10d. Inside City Limits 13€ Yes 2 □ No
	Ba-f	Director	FL Jackson		Marianna			140		
	A Por	늅	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	9ath	Funeral	2813 Popular Sprin	g Rd.  12. Was Decedent 8	Ever in II S 11	32446 3. Was Decedent of I	dispanie Origin? (St	pacify Vas or No-	USA 14. Race - Am	erican Indian
	ter de	Ä	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cub	an, Mexican, Puerto	o Rican, etc.)	Black, Whi	
336	urs af	by	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2Ñ No	Specity:		Specify: B	lack
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23a or 28a-f show event, the Modical Esanical must be notified at	ted	15. Decedent's Edu		16a. De	edent's Usual Occup	pation	. 1	6b. Kind of Business	/Industry
215	hin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life	ve kind of work done . DO NOT use retire	during most of word d)	king		
21	d withing giene.	МО	9th grade	- Consistent of the consistent of the consistent of the consistent of the consistent of the consistent of the consistent of the consistent of the consistent of the consistent of the consistent of the consistent of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the consistency of the cons		ol Bus Dr	iver		Transport	tation
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Maryland	and and le mu		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	iling Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
2	es 1 and 2 should b of Health and Ment of Item 27 is marked r other treumatic		Earline Lee/daught	er		Walden R		-		
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Ë	tmen tent:		4 □Donation 5 □ Other (Specify)		New Libe	rty Hill emetery	Church			
Baltimore,	permit. Page Depertment of Importent: If any injury or once.		21. Signature of Funeral Service License	1600		22. Name and Addre	ss of Facility Ma	arshall's	Funeral 1	Home
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4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ac Arrhyth	mia/Asyst	ole			
	Examiner				a consequence of):					10 1
		e.	Sequentially list conditions, if any, leading to immediate		rdial Infa a consequence of):	erction				10 weeks
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Вох	eath certific attending p for use as	N/N	230. Was decedent pregnant	3c. If yes, outcome		B Ectopic pregnanc	v		23d. Date of de	
	deal ne att	sicie	in the past 12 months? 1 ☐ Yes 2 ☒ No	4☐Pregnant at		Other (specify)	,		Month	Day Year
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Division	r Attending er death. rector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home, farm,				eet and Number or F	Rural Route Number,
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	To the Hos within 24 h To the Fur completely	ledical	one)	and manner sta		investigation, in my	pinion, death occu		te and place, and du	
	To the Hi within 24 To the Fi complete	Σ	29b. Signature and title of certifier	1 1	9	29c. Licen	se number	29	d. Date signed (Mor	oth, Day, Year)
	<i>C.</i>		· XII	No y	0/	D1627	3MD		75/	/ / 4.
2	0		30. Name and address of person who co						-	
_			Revathy Murthy, M 31. Date filed (Month, Day, Year)		ar's Signature	130 Lando	ver Rd. C	heverly N	AD	
	Sta Registr			SUL 32. HOGOLIA	A ark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Jean B. Pannell 10 10:02 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Southern Maryland Hospital Clinton, Maryland Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F b2//28/1935 Director Washington, DC 74 78-50-1084 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Capitol Heights Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 7425 Walker Mill Drive 20743 United States permit. Page 1 and 2 should be filed within 72 hours after death valepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Voucher Examiner U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ June Bolden Inez Duff Bolden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7425 Walker Mill Drive, Capitol Heights, MD 20743 Jovce Smith (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Memorial Cem. 2/19/2010 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Pope Funeral Homes, PA, 5538 Marlboro Pike arry MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Preumonia Physician/ Mato railling disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 nding p. IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 3 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide within 24 hours after dear To the Funeral Director completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Terpifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man we as stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) MIT Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND#2perMD, 2/12/10, BMW, McCo Certificate of Death Reg. No. 2. Date of Deat Feb 5, 2010 1. Decedent's Name (First, Middle, Last) **Physician** :07-PM 400 PHUCAS 2010 74 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howars HOWARD COUNTY GENERAL Coumbia HOSPITAZ 8. Date of Birth Aug. 1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Mary land 579-30-3108 1 □ M 2 🖾 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Experiment rust be notflied at 1 ☐ Yes 2 🖾 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 USA 9019 Flower Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White à If Yes. Give 3 Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental h Be Ethel Beatrice Sorrell Clifton Curtis Stephens ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an 4201 Lynn Burke Road, Monrovia, MD 21770 Irving E. Stephens/Brother Date 20c. Location - City or Town, State Pages 1: iment of H tant: If ite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 12 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** SHOCK 72 HUVRS /Medical Due to (or as a consequence of): Examiner 21 DAYS PNEUMONIA Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the. attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ OBSTRUCTIVE PULMANARY 1 ☐ Yes 2 ☐ No 3 Trobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑No 24a. Was an certificate has page 2 autopsy 1 ∐Yes 2 🕱 No 2 No of Vital I or Attending Physician: after death. Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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31. Date filed (Month, Day, Year) FEB 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DAVID

U. NYANJEM MO 10710 CHARTER OR SUITE 310 3. Registrar's Signature

29c. License number

136974

29d. Date signed (Month, Day, Year)

FEB 7, 2010

COLUMBIA MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Physician/ Donald Ray Rawlings Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMRMC-WM Health System Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Director 233-70-0011 66 July 16,1943 Bloomington, MI Usual Residence of Decedent 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County Director notified 1 Yes 2 X No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be r Funeral Rt. 4, Box 181-B USA 26726 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status "natural", or itel idical Examiner Completed by 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) "r than ", College (1-4 or 5+) Elementary/Seconday (0-12) Tire Builder 12 Tire Manufacturing marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Thomas F. Rawlings Blanche A. McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca L. Rawlings/Wife 4, Box 181-B Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Feb. 22 2010 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injuny Potomac Memorial Gardens Keyser, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Inset and Death Immediate Cause (Final Physician disease or condition resulting in death) Respiration Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed mon physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No Month Other (specify) Pregnant at time of death been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy perform 1 ☐ Yes 2 X No Yes 2 X No After this certificate funeral director, pag 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo
completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 18/2010 10065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Ravi Aiyer, M.D.

31. Date filed (Month, Day, Year)

3 2K 32. Registrar's Signature

12500 Willowbrook Road Cumberland, MD

Hease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Physician/ 08 8:00p M 2010 Carol P. Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Suburban Hospital</u> Bethesda Montgomery If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 1 X M 2 A F Months Days Hours Min. (Month, Day, Year) 04/25/1917 92 Director Yrs. 229-01-1616 VA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show annotant. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No NONE Washington DC 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1240 Oates St. NE USA 20002 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates 1942–46 16a. Decedent's Usual Occupation

Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) College (1-4 or 5+) Flementary/Seconday (0-12) Computer Operator Federal Government 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Robinson Moses Robinson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1240 Oates St. NE Washington DC 20002 Dorothy M. Robinson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/20/2010 Laurel, MD Maryland Nat. Cem. . Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 🔀 No 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural 1 Tes 2 🗌 No Accident Investigation Suicide
Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical 1 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Chablani Gul,

31. Date filed (Month, Day, Year)

FEB 1 6 2010

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DI 17507

11119 Rockville Pike, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-32. Registrar's Signature

Michael Figaro, M.D.

31. Date filed (Month, Day, Year)

FEB 1 6 2010

**Physician** /Medical

Examiner

attending physician and for use as the burial-tran ģ To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

2. Date of Death Day Year February 8,2010 4b. City, Town, or Location of Death 4c. County of Death Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/23/1909 Edgecomb Co., N.C. 10d. Inside City Limits Yes 2 No 10g. Citizen of What Country? U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Afriçan-Specify: American 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Industry 18. Mother's Name (First, Middle, Maiden Surname) Mariah Bowel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6905 Kent Town Dr., Landover, Maryland 20785 20c. Location - City or Town, State Maryland Nat'l. Mem. Park 02/19/10 Laurel, Maryland 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Approximate Interval Between Onset and Death 23a. Part I. Enter the durase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Dysrhythmia Due to (or as a consequence of) Cardiopulmonary Collapse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Cardiac Dysfunction resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown Advance Age Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal Insufficiency autopsy 2 No 1 □Yes 1 Yes Cardiomyopathy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11th 2010 tebinan D52865

DHMH 17 Rev 1/2001

State

Registrar

3001 Hospital Drive, Cheverly, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 3.056 M **Physician** 2010 Roberta Kern Rosenfeld /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home Rockville Montgomery Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, July 9, **Funeral** Year) Months Days 1 □ M 2 🔀 F 74 1935 Director 230-42-2156 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a, State 10b. County d other than "natural", or items 23a or 28a-f sho event, the Medical Expriger must be negliged at 1 ☐ Yes 2 XNo Director Maryland Montgomery Germantown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? within 72 hours after death with 18521 Eagles Roost Drive Funeral 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, IT's IM. Elementary/Secondary (0-12) College (1-4or 5+) National Institute of Grant Reviewer Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur Be Benjamin Kern Diana Wilensky ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Rosenfeld/daughter 18521 Eagles Roost Drive Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Final Journey Crematory 2/15/2010 Woodbine, Maryland 21. Signal re of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 uanta M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ardio /Medical Due to (or as a consequence of): Examiner can Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No P.O. the detached 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform certificate 2 **W**o 1 ☐Yes 2 ☐ No 1 ☐ Yes of Vital Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Provible 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal Medi and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of person who completed cause of dea

th, Day, Year) FEB 1 6 2010

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Registrar's Signatul

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DOOS 362 Riva Selya Sheet Rock,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 15 2010 3:57  $a^{M}$ Caroline D. Roebuck Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Dove House Westminster If Under 1 Year If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 1 - M 2 XF 1929 Director 163-24-6106 80 October Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo Ellicott City MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3114 Ramblewood 21042 United States Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1.
Department of Health and Mental Important: If item 27 is many injury or other. ٥ Isabella Frew William Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5830 Westchester Hills Ct. Sykesville, MD 21784 Alan D. Roebuck - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/15/2010 Ardent Crematory Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M00845 rune of Funeral Service Licensee ndre P amouto 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RLEEDING Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initial clate cause. Enter Underlying Examiner Due to (or se a consequency of) Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ᠓ No 24a. Was an autopsy performed? Yes 2 No Yes director, 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 🐧 No ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of completed filled in by the funeral Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 15

Registrar

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 1:23 p.^M Helen Kathryn Shay Feb. 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Goodwill Mennonite Home Grantsville Birthplace (State or Foreign Country) If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F Director 218-16-3735 85 April 3,1924 Franklin, MD Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD **Allegany** Frostburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 265 E. Main Street Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify þ Specify. 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Bartender Bar/Social Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Henry Raines Janet Virginia Dunn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael W. Shay/Son 265 E. Main Street Frostburg, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation Feb. 23 3 Removal from State LaVale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Restlawn Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ZHEIME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) P.O. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate I 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/22/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, M.D. 124 Miller Street Grantsville, MD 21536

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

AR 0 1 2010

DHMH 17 Rev 1/2001

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Februan Physician/ Philip Grosvener CYUL AM Slauson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. (Month Day, Year) ay 2, 1923 New Jersey 157-22-7070 86 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mechal Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 W. Baltimore Street Apt. 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Account Representative Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) P Jonathan Sayre S1auson Marguerite Soney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Doarnberger /sis-in-lav 5978 Camelback Ln., Columbia, MD 21745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Dremation 3 Removal from State Smithsburg Crematory 2/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Sign July of Funeral Service Low see 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ meumoria Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate has ral director, page 2: performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

32. Registrar's Signature

Drive Keedysmile, MD 21756

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Discotors   Name   Print, Model   Land   Name   Print, Model   Land   Name   Print, Model   Land   Name   Print   Name   Print   Name   Print   Name   Print   Name   Print   Name   Print   Name   Print   Name   Print   Name   Print   Name   Print   Name   Print   Name   Name   Print   Name   Print   Name   Name   Name   Print   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name   Name				for State Registrar	e of Maryland / i	-	rtment of F ificate of D		Mental Hy	giene Reg. N	2010	0585	56		
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Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Social Security Number   Color   Color   Social Security Number   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color   Color		Medic	cal	·		r.	4b City Town or	Location of Death				<del></del>	ММ		
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Usual Residence of Decedent   10c. City, Town or Location   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Inside City Unity   10d. Insi				5. Social Security Number 6. Sex 1 X M 2	F				8. Date of Bir	th	9. Birt	hplace (State or For	eign		
Nathan Simmons, Sr.    Nathan Simmons, Sr.   Rosetta Jenkins				Usual Residence of Decedent					1 10-03	.u 16	.L   3.				
Nathan Simmons, Sr.    Nathan Simmons, Sr.   Rosetta Jenkins		aryland a-f sho fied at	ector				ation					,			
Nathan Simmons, Sr.    Nathan Simmons, Sr.   Rosetta Jenkins		or 28	P	Maryland Prince George 10e. Street and Number	es   Lannar	m	10f. Zip Code		1	10g. C	itizen of What Co	^			
Nathan Simmons, Sr.    Nathan Simmons, Sr.   Rosetta Jenkins		h with 1s 23a nust b	nera			,				Ц	AZI				
Nathan Simmons, Sr.    Nathan Simmons, Sr.   Rosetta Jenkins	^	or iten or iten niner r		11. Marital Status 12. Was I Arme	Decedent Ever in U.S. ed Forces? Yes 2 No	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)						
Nathan Simmons, Sr.    Nathan Simmons, Sr.   Rosetta Jenkins	200	ural", ural",	ted b	I If Yes	s, Give	1	☐ Yes 2 💢 No	Specify:			Specify: Bla	ack			
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20a. Method of Disposition    20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)	and	ntal Hy red oth									Surname)				
20a. Method of Disposition    20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)	a Z	nould trud Me s mark umatic		Macrial Stimolis 21 - Mesessa sellation								Code)			
Cedar Grove Cemetery   02/13   2010   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena Islanda   St. Helena	_	nd 2 st lealth a m 27 it			iece 6	921	Lamont D								
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  End Stage Prostate Cancer with  Due to (or as a consequence of):  Metastates and Cachexia  Due to (or as a consequence of):  Metastates and Cachexia	nore	age 1 a nt of H t: If ite roroth		XX Burial 2 ☐ Cremation 3 ☐ Removal	from State cemeter	ry, crema	atory or other place		. /		-		S.C		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  End Stage Prostate Cancer with  Due to (or as a consequence of):  Metastates and Cachexia  Due to (or as a consequence of):  Metastates and Cachexia		mit. Pa partme portan r injury			Cedar								7.		
Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Examiner  End Stage Prostate Cancer with  Due to (or as a consequence of):  Metastates and Cachexia  Due to (or as a consequence of):  Due to (or as a consequence of):	ň	an Jeg		Asie W. Zu	el and	ا ا	500 Alle	ntown Rd	-¬ Camp	Spr	ings, MI	20748			
disease or condition resulting in death)  Medical Examiner  Sequentially list conditions, if any, leading to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to immediate to				shock, or heart failure. List only one cause on each line.  Interval Betwee Onset and Dea  Onset and Dea											
Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		Medical		disease or condition			ate Canc	er with				Shopt and Boats			
E if any, leading to immediate Due to (or as a consequence of).		Examiner	<u>.</u>	Sequentially list conditions, b			Cachexia	1				yr			
The first initiated events resulting in death) Last    Color   Due to (or as a consequence of):		ed sit	mine	cause. Enter Underlying			ve					V.C			
This coll it is a second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be set of the second to be second to be set of the second to the second to		execut an and rial-tra	Exa	that initiated events C. ———	· · ·		la = w d					-/-			
FEMALE:   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 5   Other (specify)   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   No 4   No 4	3	ate be chysici the bu	dica	d	Twwdniiir	27.uc	rome:					yr			
in the past 12 months?  1	200	certific nding puse as		23b Was decadent pregnant 23c. If yes	s, outcome of pregnancy						23d. Date of del	ivery			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Incontinence c: bladder and bowel  23e. Did tobacco use contribute to the cause of death?  Incontinence c: bladder and bowel  24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Yunkn  24a. Was an autopsy performed? 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   Yes 2   No 1   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2	ָ מ	death he atte ed for	sicia	1 Yes 2 KNo	Pregnant at time of death		у			Month	*				
Incontinence c: bladder and bowel    1   Yes 2   No 3   Probably 4   Vunkn	j :	nat the ed by t detach	y Phy	9 LJ Ofiknown									,		
24a. Was an autopsy findings availa prior to completion of cause death?  1	S.	luires t en signe uld be	ed p	Incontinence of bladd	er and bowel				1 🗆	Yes 2	No 3□Pr	robably 4 🗷 Unkn	own		
Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Section   Sect	000	law rec las bee	nplet						auto	osv	prior to c	topsy findings availa completion of cause	ble of		
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27. Manner of Death    27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury		ysicia is certi directo		examiner? Hospital:	1 ☐ Inpatient 2 ☐ ER/Ou	utpatient	Othe			dence	6 ☐ Other (Speci	(fv)	_		
2 Accident Investigation 3 Suicide 6 Could not be determined determined building, etc. (Specify)  2 Accident Investigation 3 Suicide 6 Could not be determined building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	0 .	ing Ph		1 Natural 5 ☐ Pending			work'	at ?				,			
building, etc. (Specify)	SIO	Attend r death ctor: / by the f	rtific	2								al Route Number,			
	5	tal or virs after all Dire		4 - normicide determined b	ouilding, etc. (Specify)			Į,							
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Ppacitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	:	Hospi 24 hou Funer eted fil	edica	(Check 2 Medical Examiner: On the	e basis of examination and/o	or investig	gation, in my opinio	n, death occurred a	t the time, date a	and place	e, and due to the o	ause(s) and manner s	stated.		
only one) 3 Certifying Nurse Precisioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and tiple of certifier  29b. Signature and tiple of certifier  29c. License number  29d. Date signed (Month, Day, Year)	:	To the within To the compl	Σ		her: To tige best of my know	leage, ae			ce, and due to th						
1 Cellen Ruley MD 054749 February 5, 2010				Illen Ku	very 1	11	054	749		Fel	orvary:	5, 2010			
2 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, MD 801 Toll House Ave. D-1 Frederick, MD. 21701	2	6		4 1 / - 1 /	cause of death (Item 23a) (	Type, Pr	e Ave.	D-1 F	reden	ck	, MD.	21701			
State Registrar  State  31. Date filed (Month, Day, Year) Registrar  32. Registrar's Signature					32. Registrar's Signature	1	A I P COM		1 - 1 - 1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05857 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 4, 2010 **Physician** Roland Hudson Somerville 1340 hrsM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 1948 **Funeral** Months Days Hours 1 X M 2 □ F 61 Massachusetts Director 010-36-4316 November 6. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 23a or 28a-f show other traumatic event, the Medical Examiner must be putting at 1 X Yes 2 □ No Director Washington Hagerstown Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 United States 18226 Roycroft Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: **Black** Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) **Auto Parts Stores** Auto Parts Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Cora Butler Arthur G. Somerville, Sr. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health aitem 27 is 18226 Roycroft Drive; Hagerstown, Maryland 21740 Peterson (Daughter) Monica 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any Injury or o Feb 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Riverdale, Maryland Riverdale Park Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Andre Sanders & Sons Mortuary 21. Signature # Funeral Service Licensee Services, LLC; 7908-B Kincannon Place; Lorton, Va. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760. Physician/Medical P.0. Par Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hours and

Completed by Be Medical Certification: To

25

27.

29b. Signature and title of certifier

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	23d. Date of delivery Month Day Year
Part II. Other significent conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Coronary Art	ery Disease	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown
Cardiomyopat Diabetes Mel	24a. Was an eutopsy performed? 1 □ Yes 2 <b>1</b> No	
25. Was case referred to medical	26. Place of D	eath (Check only one)
examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 Impatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Naccident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Unjury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

D38262

29d. Date signed (Month, Day, Year) February 4, 2010

20850

State Registrar

Anurita Mendhiratta, M.D.;2401 Research Boulevard; Suite 330; Rockville, Maryland 31. Date filed (Month, Day, Year) FEB I 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** SteeLe 2:35 P.M 02 2010 Moses /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Crownsville
If Under 1 Year | If Under 24 Hrs. Nursing & Kehab. Center Anne ArundeL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) Months Hours Davs 1 M 2 □ F 247-32-6750 82 9-01-Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a, State permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic event, the Modeal Expression to other traumatic events are event to other events at the expression traumatic events are events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at the events at th 1 Yes 2 □ No GRORGE'S Funeral Director MD WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1910 BelFas DRIVE 20744 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗖 No If Yes, Give Year or Dates: Completed by Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction ROOFER 10 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Steele Hattie Masse Kandolph ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1910 BelFast Drive Ft. WASHINGTON, MD. 20774 Steele - DAUGHTER Saundra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/19/2010 Suitland, MD WASHINGTON NAT. CEMETRY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature Funeral Service License Allentown Road Camp SPRINGS, MD. 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due v (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to initioal accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 □No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ►No 24a. Was an autopsy performed? 1 □Yes 2 MNo funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 24 hours after death. e Funeral Director: Aff 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Se Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one)

State Registrar 29b. Signature and title of certific

29d. Date signed (Month, Day, Year)

29c. License number

who completed cause of death (Item 23a) (Type, Print)

Barne HWY th, Day, FEB 1 6 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Ma	ryland /					d Mental H	ygien	9			
			State Registrar			Cer	tificate (	of De	ath	0.5	Reg. No	20	0	05	359
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1	/Medic		4a. Facility Name (If not institution, give si	HROED	EK		4b. City. Tov	vn. or Lo	cation of D	eath	40	County of	Death	12	- SOPM
1	Examir	er	Cherry Lane Nursi		•		4b. Oity, 101		ire1			,		orge'	S
25.0	Funeral	7	5. Social Security Number 6. Sex	7. Age	(In yrs. last	birthday)	If Under 1 Y Months D		Under 24 I	Hrs. 8. Date of E	Birth Da <i>y, Y</i> ea <i>r</i>	.)	9. Birthpl	ace (State o	or Foreign
	Director		215-20-6592	M 2 K	84	Yrs.	Months	ays r	nours in	October	13,	1925 (		erland	d, MD
	put w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation						1	0d. Inside Ci	ity Limits
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	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decedent If Yes, specify	t of Hispa Cuban, I	anic Origin Mexican, P	? (Specify Yes or I	No-	14. Race Black,	- America White,		
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give	lo		1 ☐ Yes 2 🛭	No s	Specify:			Specify:	Whi	te	
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	permit. Pag Department Important: I any Injury c	1	21. Signature of Funeral Service License	e	712020	-	2. Name and A	_			1			ore A	
ä	Der Jany	. 10	Jamis Hath	man		Ga	asch's	Fune	eral 1	Home, P.A					
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39 >	ertifice ing ph e as tl	Med	IF FEMALE:											-	
Вох	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Fetal de	eath 3	Ectopic preg					23d. Date Mon		ery Day	Year
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or/	Physic this c	၉	1 ☐ Yes 2 No	lospital: 1 ☐ Inpatie 28a. Date of Inju		l/Outpatier		Other:	4 Nursi	ing Home 5 R				fy)	
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	lospit hour unera		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best	of my knowle f examination	edge, deat	th occurred at	the time	, date and nion, death	place, and due to to occurred at the tire	the cause ne, date a	(s) and mar	nner as s ind due t	stated. o the cause	(s)
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,	/		30. Name and address of person who co	impleted cause of d				/ -					1		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEB.  $20\overset{\text{Year}}{10}$ **HENRY** SPLISTISER J. 12:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY RIDERWOOD SILVER SPRING Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) JUNE 24 1 🛛 M 2 🗆 F Months Days Hours Min. RHODE **Director** 035-05-1260 92 ISLAND Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3142 GRACEFIELD RD. #610 20904 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Yes 2 No 1 Never Married 2 🕅 Married "natural", or Completed by 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced WWII Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 SECTION MANAGER GOV'T. FED. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve CHRISTIAN SPLISTISER WILHELMINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPLISTISER/WIFE 3142 GRACEFIELD RD. #610, SILVER SPRING, MD. Α. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FEB.5, 2010 CHAMBERS CREMATORY RIVERDALE, MD. Signature of Funeral Service Licensee any in 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Chambus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. METASTATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): and I-transit Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last -bunialattending physician I for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months? Month 2 No the s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALZHEIMERS DISEASE 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy performed?
1 ☐ Yes 2 🔯 No death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Sp. မ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Division of Vital Records, within 24 hours after death.

To the Funeral Director: A completed filled in by the funeral process.

Maryland 21215-0036

Baltimore,

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

(Month, Day, Year) FEB 12 2010

3110

(Clerkon MD

Mp

3. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D44156

29d. Date signed (Month, Day, Year)

29c. License number

acefield Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e 19b per inf e901 3-11-10 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ST. **Physician** Smith dward e 2010 lames /Medical 4c, County of Death 4b. City, Town, or Location of Death ac Facility Name (If not institution, give street and number) **Examiner** Trince 7. Age (In yrs. last birthday) neveo Jeorge' orge 5e H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Month, Day, 9. Birthplace (State of Foreign Country) Social Security Number 6. Sex **Funeral** Months G 1 M 2 □ F Feb, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Modical Experience must be notified. 1 ☐ Yes 2 ☐ No Director YTINCE Utorge's Capitol laryland 10g. Citizen of What Country? 10e. Street and Number Peppermill 20143 united Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Eyer in U.S. Armed Porces? 1 - 28 - 1454 1 Pres 2 Nog - 6 - 1456 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Arm 1 ☐Yes 2 ☑No Black Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Privat ucato 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Smi Heights, MD 20743 20b. Place of Disposition (Name of camatery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20,2010 (Freensville 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grenesis Cremcetic 5732 CA, Ave. Signature of Funeral Service Licenses Wash NEW Approximate Interval Between Onset and Death 23a. Part 1. En er the disease, or complicators that leaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Occ teria **Physician** /Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □ No 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 🛂 No 1 □Yes 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes After this 27. Manus of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Autonomic Within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28161200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive; Cheverly, MD 20785 Karren R. Brooks, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 12 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 2010 6:17 Р John N. Stanley, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/17/1933 5. Social Security Number 7. Age (In yrs. last birthday, 1 X M 2 □ F 211-26-8182 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Ocean Pines Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 USA 26 Driftwood Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Engineering Electronics Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith M. Welsh John N. Stanley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26 Driftwood Lane, Ocean Pines, MD 21811 Faith Stanley / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 2/10/2010 Frankford, DE 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each life. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) hemmohose Intra cere bra Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or inju that initiated events resulting in death) Last Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

10a State

MD

Director

Funeral

2

Completed

Be

Examiner

**Funeral** 

Director

Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantract must be notified at any injury or other traumatic event, the Medical Evantract must be notified at agree.

Baltimore, Maryland 2121

attending physician and for use as the burial-tran

Be Completed by Physician/Medical Medical Certification: To

55# 211-26-8182 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

> DN 10+1 State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of 9 ☐ Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyi	ng cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
	Embolism			1 ☐ Yes 2	Probably 4 Unknown
				24a. Was an autopsy performed? 1 □ Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ♣ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1  Yes 2 <b>X</b> No	Hospital: 1 Inpatient 2	] ER/Outpatient 3	DOA Other: 4 Nursing !	lome 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		nome, farm, street, fac ffy)	ctory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, te)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occu ation and/or investiga	erred at the time, date and place ation, in my opinion, death occ	e, and due to the cause( urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier			29c. License number	29d. D	ate signed (Month, Day, Year)
M'	D .		1)0064120	2,	19/2010
30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)			

Berlin MD 21811

DHMH 17 Rev 1/2001

Registrar

Freeshan 31. Date filed (Month, Day, Year) FEB 12 Houlth way Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Feb. Bernice Frances Scott 14, 2010 4:15a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Manor Health Care Center Rising Sun Ceci1 8. Date of Birth (Month, Day, Year)
Nov. 28, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🔽 F Months Days Hours 90 Yrs. TN 214-10-6984 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show iral", or items 23a or 28a-f shov 1 Yes 2 No Director MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Hermitage Dr. 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify. þ Specify: White 3 Widowed 4 ☐ Divorced "natural" Completed th and Mental Hygiene.

7 is marked other than "natul traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Edward Stephen Routon Philena Carolyn Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 210 Friendship Rd. Elkton, MD 21921 Ellis A. Scott/ stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. Foard and Gee 21. Signature of Funeral Service License 259 E. Main St. Elkton, MD 21921 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an s certificate has be irector, page 2 st autopsy perform 2 No 1 TYes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife 29c. License number

SHIVA

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

SACHDEN MD, 126 A, E 32. Registrar's Signature

Sachcler. 5 M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2.15.2010

196 St, Ecklon MD 2921.

State of Maryland / Department of Health and Mental Hygiene 05864 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Pay 7, 2010 **Physician** 1:50 PM K. Swaim Frances /Medical 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hyattsville Sacred Heart Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 🕱 F Yrs. Oct 4, 1912 Massachusetts Director 97 027-01-1329 Usual Residence of Decedent should be filed within 72 hours efter death with the Marylend nd Mental Hyglene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County item 27 is marked other than "naturel", or itams 23s or 28e-f show other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Hyattsville Maryland Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20782 5805 Queens Chapel Road Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 € Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) s and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Quality Control Inspector 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Banek Kolasinski Salomea Francis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an 5410 Manning Place, NW Washington, DC 20016 Item 27 Salomea Swaim/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Importent: If Its any Injury or o once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Final Journey Crematory 2/15/2010 Woodbine, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Lanta Momas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknown **Physician** Alzheimer's Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed burial-transit Exami Due to (or as a consequence of): Physician/Medical d the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Year Month Dav ō in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown dementia, psychotic agitation, adult failure to thrive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an anemia autopsy performed has page 2 1 Yes 2 No 1 Yes 2 🔼 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 28b. Time of 27 Manner of Death Certification: After Injury 5 Pending 1 Naturat 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after hours Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 within 2 To the 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier Chow dly D43121 February 12, 2010 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) M.D. 15216 Dino Drive Burtonsville, Maryland 20866 Nurul Chowdhury, 31. Date filed (Month Registrar's Signature 32. State RACIA Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 February Margie Irene Sexton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forest Hill Health and Rehab Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) Harford Forest Hill 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) an 16, 1922 Virginia 1 🗆 M 2 🔀 F Months Davs Hours Min. 88 Jan Director 224-18-4439 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Virginia Fulks Run 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9684 Brocks Gap Road 22830 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 ☐XNo "natural", or within 72 hours after Maryland 21215-0036 1 Yes 2 XNo If Yes, Give Year or Dates Specify Specify: White 3 ₩ Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Victoria Cleveland John Marco Musser Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kenneth B. Sexton/son 30815 W. Veronica Avenue Eustis, Florida 32736 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 2/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licensee Cremation Service p.O. Box 784 <u>Heckrotte, P.A. Clarksvil</u>le, M Going Home M00957 Beverly L. Clarksville, MD 21029 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in neclate cause. Enter Underlying Due to jor as a consequence of: Exami burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, Certificate: 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mly one) 29d. Date signed (Month, Day, Year, 29b. Signa itle of (b) leted cause of death (Item 23a) (Type, Print) e and address of 610 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Feb 2010 0347 Simmons Renee Α. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 52 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 212 68 72 6. Sex Year 7215 1 □ M 2 🕏 F 10,1957 Washington DO Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 □ No Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 US 8701 Reicher Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 O Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Black 1 ☑ Never Married 2 ☐ Married 1 □Yes 2 No If Yes Give Specify Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Professor Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Abraham Simmons Cora Shearin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8701 Reicher St. Landover MD Abraham Simmons/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Landover, MD Harmony Cemetery 2-20-2010 4 Donation 5 Dother (Specify) 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signature of Funeral Service Licensee MUSCOC NONIC 900 2294 Old Washington Rd Waldorf, MD20601 23a. P.rt1. Enter the diel ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart laddre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fatal Cardiac Arrythmia Due to (or as a consequence of): Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🛣 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed? Yes 20 No

28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

MD

Director

Completed by Funeral

Be

ဂ

**Examiner** 

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Modical Evan in the motified at once.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans physician the burial attending p for use as t signed by the a page 2 s certificate this

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical þ Completed Be After thi funeral of

Certification: To To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier Feb. 12, 2010 m V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5801 Allentown RD Camp Springs, MD 20746 Emerson Coronel 31. Date filed (Month, Day, Year)

State Registrar

FEB

5 Pending investigation

6 ☐ Could not be

Hospital:

28a. Date of Injury (Month, Day, Year)

25. Was case referred to medical examiner?
1 △ Yes 2 □ No

27. Manner of Death

1X Natural

2 Accident

3 Suicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

10-01395 Joele Clifton Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2010 05867

		1- For State Certificate of Death Reg. No.																
Physicia dical Exami	an/	1. Decedent's Nam											2.	Date of Dea Month February	Day 16, 20			3. Time of Death 0844 hrs
		4a. Facility Name ( 408 W. Wa	if not institution	n, give	street and nu		<del>.</del>			. City, Tow Hagerst		ocation of			4c.	. County of Vashingt		
Funeral Director		5. Social Security I	Number	6. Sex			e (In yrs. la	st birthday) 34 Y	ı	If Under 1 Months	Year Days	If Under Hours	24Hrs. Min.	8. Date of Bi	,		Cou	place (State or Foreign ntry)
51100101		217-04-3 Usual Residence of		1 A	M 2F			34 1	rs.			<u> </u>		03/08	1/19/	/ 5	1.	
any		10a. State	10b. County				10c. City,	Town or Loca	ation	n				_			$\neg$	10d. Inside City Limits
ith the Maryland 23a or 28a-f show any notified at once,	'n	MD	Washi	ngt	on		Hag	erstov	√n								لــــــــــــــــــــــــــــــــــــــ	1 X Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Nu	mber							10f. Zip Co						zen of Wha	t Count	ry?
h the 3a or		408 W.Wa	ashingt	ton					Д.		.740		-2/6	if. Vac as N		SA 14 Page	Americ	an Indian, Black,
eath with the items 23a ust be not	Funeral	11. Marital Status  1 X Never Marri	ied 2 N	larried	12. Was Dec Armed F	orces?	,			s, specify (				cify Yes or Ni ican, etc.)	0-	White,		ar malar, Saok,
P 2 €		3 Widowed			1 X Yes		No	1	] Y	res 2X	No	specify:				Specify:	Wł	nite
2 hours afte "natural", Examiner	d by	15. Decedent's E			or Dates:		npleted)	16a. Deced	ent's	s Usual Oc	cupatio	on (Give k	ind of wo	rk done	16b. F	Kind of Bus	iness/In	dustry
72 ho	Completed	Eiementary/Sec	ondary (0-12)		College (	1-4 or	5+)	3			•	DONOT	13C 1CUIC	۵,	_		3.6	G t
0036 within 72 iene. er than Medical	тр	12						As	se	emble		8 Mother's	Name /f	irst, Middle,			Mai	nufacture
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	BeCc	17. Father's Name												Effla		Camaino,		
T 교육 열하	To B	19a. Informant's N			pe, Print )			19b. Maili	ng /	Address				ral Route Nu		ity or Town	, State,	Zip Code)
E 0 - 0 -		Janet R		make	er/Moth	ner								k, MD			011	Chata
re, M s 1 and 2 f Health a f item 27 er traum		20a. Method of Dis	sposition  X Crematio	n 3	Removal f	rom St	_	Place of Disp crematory or	ositi othe	ion (Name er place)	of cem	netery,		Date	20c.	Location -	City or	Fown, State
Pages nent o ant: ]		4 Donation 5	Other S	Specify:				ithsbu						5/201				
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		21. Signature of F	Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street													et		
		23a, Part I, Enter t	M00260 Grove Funeral Home, P.A. Hancock, M. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h												ock, or hea	<u>Z1</u> /rt	Approximate Interval	
Physician // // // // // // // // // // // // //		failure. List o	failure. List only one cause on each line.															Between Onset and Death
Examiner		Immediate Cause or condition result		ī	Due to (or as	a cons	equence of	f):	<u> </u>	вере								
	<u>_</u>	Sequentially list o			Acute Due to (or as				_	_				_				
	mine	cause. Enter Und (Disease or injury	erlying Cause	C.	Due to (or as			۴۱.	_									
ited J ansit	e e	events resulting in	n death) Last	d.	Due to (or as	a cons	equence or	1).										
760, icate be executed physician and the burial - transit	n/Medical	X UNPENDE	)					PII,2	7,	permI	Ξ, ε	3901	3/ <u>3</u> 0	/1 <u>0 T</u> 7	]		1-11	
8760, tificate being physicias the buri	n/Me	IF FEMALE: 23b. Was deceden		the	1 Live	birth	me of pregi	2	Feta	al death	3 [	Ectopic	pregnan	су	23	d. Date of o		ay Year
Box 68 te death certi	Physicia	past 12 month		nknown			t time of de	eath 5	Othe	er (Specif	v) _							
b. Be the de	Phy	Part II. Other sign		itions	- Land		th but not re	esulting in th	e un	nderlying c	ause g	iven in Pa	rt I.	23e. Did				he cause of death?
P.O. es that the igned by oe detac	<u>a</u>		nic alo											1 🗌 Y	es 2	No3[	Prob	ably 4 🗸 Unknown
ds, require seen si tould b	Completed													24a. Wa	s an opsy	24b. W	ere au	topsy findings available ompletion of cause of
e law e has l ge 2 sh	g													per	formed?	d	eath?	_
I Re n: Th rufficat or, pag	ပ္စိ	25. Was case refe	erred to medic	al	·					26		of Death	<u> </u>					
Vita vysicia this ce	e.	examiner?	2 No	F	lospital: 1	Inpati	ent 2	ER/Outpation	ent					Home 5				: Scene
on of anding Pt tth.	tion: T	27. Manner of De	5 🗌 Pe	nding	28a. Dat (Mon	e of Inj th, Day,	jury Year)	28b. Time (	of In	ijury 28	_	ry at Work res 2		28d. Describ	e how inj	jury occurre	∌d	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	1   Natural   5   Pending   Investigation   2   Accident   Accident   Suicide   6   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not												ral Route Number, City					
Hospit n 24 hour ne Funera	cal Ce	4 Homicide  29a. Certifier (Check only one)		Physic	ian: To the be	est of r	my knowled amination a	Ige, death oc	curr	red at the ti	me, da	ate and pla , death oc	ce, and c	due to the ca	use(s) a te and pl	nd manner ace, and d	as state ue to th	ed. e cause(s)
To the within To the comp	Medical	29b. Signature ar			and manner	stated	1.	/	-			e number						nth, Day, Year)
			111/	//	~		X	M	1		O.C.I	M.E.			Fel	bruary 1	7, 201	0
		30. Name and ad							1			_			-			
		Russell Al			Assistant				11	Penn S	treet,	Baltimo	ore, MD	21201		005	45	
Regi:	State Stra		onth, Day, Yea		32.	registr	rar's Signati	bark	2	9						£00%		
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O OLUE OOOC																		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05-2010 LLOYD CLINTON TRUEHEART, SR. 16:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 □ F Min. (Month, Day, Year) 05-31-1936 Hours Yrs Director 577-46-8682 73 Usual Residence of Decedent show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f Prince George's 1X Yes 2 No Marvland Suitland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20746 USA 6122 Davis Boulevard or items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black rear or Dates.1960-1962 "natural", 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Trueheart, Sr. Sadie Trueheart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health attem 27 Lloyd C. Trueheart, Jr./son 5623 Fisher Road, Temple Hills, Maryland 20748 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Veterans Cemetery 02-24-2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Hedgman M01374 Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Anoxic disease or condition brain hoknowy Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown the 9 Unknown s been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hydra aphalus Records, predicine 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 24 hours after death.

Funeral Director; After this certificate has performed? Yes 2 No the Hospital or Attending Physician; in 24 hours after death. Division of Vital 25. Was case referred to medica 8 B 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ျု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h within 2. To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rointon Faralish 193446 2-8-10

State Registrar M.D.

12150 Annapolis Road, Suita 312 Glan Dale, MO 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARAGE IF AR

31. Date filed (Month, Day, Year)

1 6 2010

# ■ Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

			Pleas	e Type or Prin					•		_	
		For State Registrar		State of Ma	aryland		artment of F rtificate of		Mental Hy	giene Reg. No	0010	05869
		Decedent's Nam	ne (First, Middle,	Last)					2. Date of De			3. Time of Death
Physicia /Medic		Dorothy	М.	Trimble						2010	)	5:00pm M
Examin	er			give street and number)				r Location of Deat	th		. County of Deatl	_
Funeral		5. Social Security I		Hospital 3. Sex 7. Ag	e (In yrs. la	ast birthday)		If Under 24 Hrs	8. Date of Bir	th	ince Geo	nplace (State or Foreign
Director		579-50-5	5095	1□ M 2 <b>전</b> F 7	2	Yrs.	Months Days	Hours Min.	Feb 22	193		untry) Ch Carolina
and		Usual Residence of 10a. State	of Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
Maryl Ff sho	to	MD	Prince	George's	Ирре	r Mari	lboro					1 ŽYes 2 ☐ No
th the	Funeral Director	10e. Street and Nu	ımber				10f. Zip Code			10g. Ci	itizen of What Co	untry?
ath wi	ral	111 Kett	tering D				20774				SA	
ter de items	Fune	11. Marital Status	ried 2 Marrie	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X]		5.   13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	)-	14. Race - Amer Black, White	, etc.
ours al	ğ	3 ☐ Widowed		If Yes, Give Year or Dates:			1∐Yes 2 <b>√⊡</b> tNo	Specify:			Specify: B1a	ack
72 ho	Completed	(Spe	15. Decedent's ecify only highest	Education grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wo	rking	16b. F	Kind of Business/I	ndustry
withir iene. than	dwo	Elementary/Sec I 2 i	ondary (0-12) th	College (1-4or 5	5+)		tary/Adm:			Gov	ernment	
be filed within 72 hours after death with the Maryland tall Hygiene. A other than "natural", or items 23a or 28a-f show event, the "he deal Evandres must be reatified.	BeC	17. Father's Name		ast)					me (First, Middle		n Surname)	
ould b Ment narked	2	Edward S							OolBerry			
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Inspartment of Health and Mental Hygiene. Inspartment of Health and Mental Hygiene. Inspartment I flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Markeal Examine must be retified at once.		19a. Informant's N		p (Type. Print)			ng Address <i>(Str</i> eet E1khorn(			_		(ip Code)
s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 and s 1 an		20a. Method of Dis	sposition		20b. Pl	ace of Dispo	sition (Name of matory or other place		Date		ocation - City or	Town, State
Page nent c ant: If ury or			5 ☐ Other (Spe	B ☐ Removal from State ecify)			e Cremato		5-2010	Rive	erdale, I	MD
ermit. Separti nport ny Inj		21. Signature of F	uneral Service Li	censee			2. Name and Addre					
ED = 60		23a Part 1 Enter	the disease or c	omnlications that caused	the death		474 Lando				, MD 2076	
<b>●</b> Physician		Immediate Cause	(Final	omplications that caused nly one cause on each li	ne.		Van	- 1	. 4 44			Approximate Interval Between Onset and Death
/Medical		disease or conditi resulting in death)	)	a. Due to (or as	a donsequ	ence of):	TUCKI	Janu	VY4			
Examiner	<u>.</u>	Sequentially list co	onditions,	b. Due to or as	~ ~ ~ ·	nujo	pally					
uted d ansit	Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event	erlying or injury		ma	YM 1	allem	dissa	70			
be executed lician and burial-transit		resulting in death)	Last	Due to (or as	e consequ	ence of):		000				
physic the b	dical			d								
leath certificate t attending physic I for use as the b	n/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome							23d. Date of del	ivery
e death	Physician/Medic	in the past 12 1 ☐ Yes 2	2 months?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ∐ Fetal at time of de		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	Э <b>у</b>			Month	Day Year
hat the		9 Unknown		s contributing to death b	out not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ildian: The law requires that the death certificate certificate has been signed by the attending physicitor, page 2 should be detached for use as the l	d by	Hy	puller	noion			, , , , ,		1 🗆	Yes 2	2 □ No 3 □ Pr	obably 4 Unknown
aw rec	Completed		Ŋ						24a. Was		24b. Were au	topsy findings available completion of cause of
	S								perfe 1 □Yes	ormed? 2.00N	death?	2 □No
slcian certifi rector	æ	25. Was case refe examiner? 1 ☐ Yes 2 ☐	1	Hospital:			ot 3 🗆 DOA Oth	or:	ath (Check only			
Attending Physician: r death. ector: After this certific by the funeral director, I	n: To	27. Manner of Dea	ath	28a. Date of Inju	ıry	28b. Time o Injury	" 3 1 DON	4 LI Nursing i	Home 5 ☐ Res 28d. Describe		6 ☐ Other (Specury occurred	cify)
tendin eath. or: Aff	catio	1 Natural 2 Accident 3 Suicide	5 ☐ Pending investiga 6 ☐ Could no	ition			M 1 □	Yes 2 □ No				
or At after d Direct I in by	Certification:	4 ☐ Homicide	determin	28e. Place of Inj building, et	ury - At ho c. <i>(Specify</i>	me, farm, str	eet, factory, office		28f. Location ( City or To	Street a wn, Stai	ind Number or Ru te)	iral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier		Physician: To the best xaminer: On the basis of								
the H hin 24 the Fi	Medical	one)		and manner st			29c. Licens		uned at the time			
<b>₽</b> 1	_	29b. Signature and	d title of certifier	who hous	•		000	1/20339	7	29u. D	ate signed (Monti	1/2010
00		30. Name and add	dress of person w	ho completed cause of c	leath (Item	23a) (Type,	Print)	11 -	. / / /	~1	everly	1. 1 1
1- 6		31. Date filed (Moi		32. Registr	1481	reri	t 6	HOSP(	4011	114	everly	Ma
Stat Registra		FEB 1		Denver D.	44	ale)					/	
										-		

DHMH 17 Rev 1/2001

	-	For State	State of M	aryland /		rtment			nd Mer		giene Reg. No.	2010	05870
		Registrar  1. Decedent's Name (First, Middle,	Last)							Date of Dea	th	· · · · · · ·	3. Time of Death
Physicia Medic		Phillip Victor	ry Thomas	Jr.						Month ebruai	v 9	Year 2010	7:35 P. M
Examin	_	4a. Facility Name (if not institution,				4b. City, To	wn, or Lo	cation of	Death		4c.	County of Deat	h
		2322 Virginia				Land						nce Ge	
Funeral			6. Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last b	irthday) Yrs.	If Under 1 Months		Under 24 lours	Min.	Date of Birtl (Month, Day	, Year)	9. Birt	hplace (State or Foreign untry)  Everly, Md.
Director		578-94-8429 Usual Residence of Decedent		45						0/22/1	964		everly, Ma.
and show	ō	10a. State 10b. County		10c. City, To	wn or Loc	ation							10d. Inside City Limits
Maryl 28a-f tiffied	rect	Md. P.O	3	Lá	andor	ær							1 🔀 Yes 2 🗆 No
a or 2	Ö	10e. Street and Number				10f. Zip C					10g. Citiz	zen of What Co	untry?
h with	Funeral Director	2322 Virginia			1.0.11		785_	. 0.1.1.	0.4016-	Yes as No		U.S.A.	
riter iner		<ol> <li>Marital Status</li> <li>Never Married 2            Marr</li> </ol>	12. Was Decedent if Armed Forces?		13. V	las Deceder Yes, specify	Cuban,	Mexican, I	Puerto Rica	an, etc.)		14. Race - Ame Black, White	e, etc.
s after death with the Maryland ra!", or items 23a or 28a-f show Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	LINO	1	☐ Yes 2	X No S	Specify:				Specify:	rıcan- merican
hour	Completed		nt's Education st grade completed)	16	Sa. Deced	ent's Usual (	Occupation	n na most o	of working		16b. Kir	nd of Business	
hin 72 ne. than '	E O	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DC	NOT use re Sport	etired)				Dr	rivato 1	Industry
d with	Be C	12th 17. Father's Name (First, Middle, L	ast)		11.01	.bpor c				irst, Middle,			industry
be file ental I ked o	욘	Phillip Thoma								ice Ni			
nd Me s mar		19a. Informant's Name/Relationsh	nip (Type, Print)	1	9b. Mailin	g Address (S	Street and	Number	or Rural Ro	oute Numbe	r, Cify or	Town, State, Zij	c Code)
d 2 stath a alth a 127 is		Loretta Thomas,	/Wife		6219	Fernw	ood .	Terr.	,# 20	01 <b>,</b> Riv	erda	le,Md.	20737
of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Pemoval from State			sition (Name natory or oth		2/	Date 22 / 201	•   n		cation - City or	
Page ment ant: I		4 Donation 5 Other (S		Chesa	apeak	e Cre	nato	ry, ir	ic.		Be	ltsvill	Le,Md.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amply injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	4. 40	22	Name and Henr	Address o	of Facility Wash	ningto	on & S	ons	Co., Inc	c.
TO = 60		23a. Part 1. Enter the disease, or		d the death. Di	149	925 Bu	rrou	ahs /	ve. I	V = V	lashi	ngton,I	C 20019 Approximate
		shock, or heart failure. List o	only one cause on each lin	e.									Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)		tensive		diova	scula	ar Di	sease	3			
Examiner								_					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequenc	e of):								
cuted and transi	Examiner	Cause (Disease or linjury that initiated events	C. Due to for as	a consequenc	re off.								
be executed sician and burial-transi	ai E	resulting in death) Last	Dae 10 (0) as	d consequence	.0 0.,.								
ath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		d										
certifi nding use a	ľ.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pr	anancy				-	23d. Date of de	elivery
death le atte	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	at time of deat		Other (spe						Month	Day Year
if the	Phy	9 Unknown Part II. Other significant condition			no in the u	nderlying ca	use given	in Part I.		23e. Did t	obacco u	se contribute to	o the cause of death?
es tha signed	Completed by	Obesity, Hype											Probably 4 Unknown
requir	etec	Seizure Disor								24a. Was	an	24b. Were au	utopsy findings available
has has been	du	Serzure Disor	der							auto	psy rmed?	prior to	completion of cause of
ificate or, pa		25. Was case referred to medical					26. Place	e of Death	n (Check or		2 - No	1	s 2 🗆 No
ysicia s cert direct	To Be	examiner? 1  Yes 2 No	Hospital:	tient 2 ER	/Outpatier	nt 3 🗆 DO	Other:	4 🗆 Nur	rsing Home	5 🗷 Resi	dence 6	Other (Spe	cify)
ng Ph ter thi neral		27. Manner of Death  1 Matural 5 Pendir	28a. Date of inj (Month, Da		b. Time of injury	28	c. Injury a work?	t	280	d. Describe l	now injur	y occurred	
tendir leath. or: Af the fu	ifica	2 Accident Investi	gation			М		s 2 🗆 I		5 )	21	/ N D	Conta Number
or At after of Direct in by	Certificate:	4 Homicide determ	28e. Place of In	ijury - At nome tc. (Specify)	, tarm, str	eet, ractory,	onice		28	City or Tov			ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledg	ge, death	occured at t	ne time, d	ate and p	lace, and c	due to the ca	iuse(s) an	nd manner as st	ated.
n 24 h	Medical	(Check 2 Medical I only one) 3 Certifying	Examiner: On the basis of Nurse Practioner: To the	examination an e best of my kn	d/or inves lowledge,	tigation, in m death occurr	y opinion, ed at the ti	death occ ime, date	curred at the and place,	e time, date and due to the	and place ne cause(s	, and due to the and manner a	cause(s) and manner stated. s stated.
Vithi Vithi Comi	-	29b. Signature and title of certifie	00				License n					te signed (Mon	
		1/ Clame	1 Di Kay	2 ~	` \		00029	70/1			гер	12,20	710
		30. Name and address of person Villamor Rev	,				Ch.	ever	lv Ma	rylan	4 2U.	785	
Sta	ite	31. Date filed (Month, Day, Year)	res, M.D. 650			Road,	<u> </u>	CACT	±y,110	T Y TOLI	4 20	,03	
Registr		FEB 1 6 2010	Denewa > B	ar's Sign ture									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For State Registrar	State of M	arylan				ealth a Death			giene Reg. No.	010	058	371
	Physici	an.	Decedent's Name (First, Middle, Last)								2. Date of De Month	Day	Year	3. Time o	
_	/Medic		Clevelan		as,	Jr.			. 55.	10 11	Februa	ry 6,			hrg.
1	Examin	er	4a. Facility Name (If not institution, give  Prince Georges 1			or		Cheve	Location o	or Death			ince (	n Georges	
2.	Funeral		5. Social Security Number 6. Se:	x 7. Aç		last birthday)	If Unde	r 1 Year	If Under		8. Date of Birt	th		hplace (State	
	Director		577-62-8107	<b>X</b> M 2□F	61	Yrs.	Months	Days	Hours	Min.	June 1	194	8 Wasi	nington	,D.C.
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	Maryl.	ō	Maryland Prince	Georges		Forest		.e							2 🗆 No
	r 28a	rec	10e. Street and Number		1		-,	p Code				10g. Citizer	of What Co	ountry?	
	th with	a D	7817 Jordan Park	Boulevar	d; Aj	pt. l		207	47			Unite	d Stat	tes	
9036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar mant be notified at	d by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	,		Was Dece f Yes, spe 1 ☐ Yes	77	spanic Ori n, Mexican Specify:		cify Yes or No Rican, etc.)		Race - Ame Black, White ecify: B1		
Maryland 21215-0036	within 72 h ene. than "natu na Mudica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade		5+)		ient's Usu kind of wi DO NOT i	ork done d ise retired	ition <i>during</i> mosi )	t ol workin	g	Fede	of Business/ ral Bu estiga	ireau o	f
D 2	e filed al Hygid other vent, ti	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,				
/lar	should be ind Mental marked o umatic eve	To B	Cleveland '	Thomas, S	r.				Ro	sali	e B1	lyther			
lan	2 should be and Mental is marked aumatic ev		19a. Informant's Name/Relationship (Ty			1	-							Zip Code) 20	
	s 1 and 2 of Heelth item 27 i		Mary Rachel Chase 20a. Method of Disposition	Thomas (		7817 Place of Dispo			ark B		vard;Ap		orest on - City or		aryla
Baltimore,	permit. Pages 1 Depertment of H important: If ite any injury or ot		1 Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	٥	emetery, crer	natory or	other place		Feb.1	9,2010				
뺥	ertme ortan injur		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fune al Service License	9/1	Mat	ional	and the second			-	the second second			ryland Mortic	ians.
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1	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that cause ne cause on each I  Sepsis  Due to (or as	a conseq		er the mo	de of dying	g, such as	cardiac of	r respiratory a	rrest,		Approxima Interval Be Onset and	tween
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687	ificate g physas the	edic		J											
.О. Вох	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	ildeath 3□	]Ectopic p ] Other (s					23d	Date of deli Month		Year
ď.	de de	by Pi	Part II. Other significant conditions con	ntributing to death t	out not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did t	obacco use	contribute to	the cause of	death?
rds	law requires es been sign 2 should be		Encephalopath	<b>y</b>							1 🗆 '	Yes 2□N	io 3□Pr	obably 4 🛣	Unknown
I Reco	The ate h page	Completed								_	24a. Was autop perfo 1 Yes		4b. Were au prior to death?	itopsy findings completion of	available cause of
Vits	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	lospital:		7		Othe	).c		(Check only o				
Division of Vital Records,	ing After	atlon: To	27. Manner of Death 1 Accident 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ıry	ER/Outpatien 28b. Time of Injury		28c. Injury Work	4 LI NU	2	ne 5 Resi			cify)	
DIVIS	ital or Attend rs efter death rai Director: ,	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	tc. (Specif	y) 					City or To	wn, State)		ural Route Nun	nber,
	To the Hospital within 24 hours e To the Funeral c completely filled	edical	29a Certifier 1 X Certifying Phy (Check only 2 Medical Exami one)	ner: On the basis of and manner st	of examina	wladge, daali ition and/or in	vestigation	at the than, in my op	ia, date en inion, dea	id place, a ith occurre	nd due to the id at the time,	cause(s) an date and pla	ce, and due	taled. to the cause(	s)
	To the To the Comp	ž	29b. Signature and title of certifier				29	c. License	number			29d. Date s	gned (Monti	h, Day, Year)	
			I glull-list	aw				77	5	77		2/	8/1	U	
			30. Nawe and address of person who co Ophne11 Cumberba				,	Dri	ve: C	heve	rlv. M:	arvlan	d 2078	35	
	Sta	te					rical		, 0	-110 7 6	/,	/			
	Registr		FEB 1 6 2010 A	32. Regist	4	alle									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A M 2/5/2010 8:30 Carroll Wright Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□ F 70 3/2/1939 577-52-4655 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantinar must be notified at 1XYes 2 No Director MD Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3510 Lancer Drive 20782 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🖾 No Specify: Specify. <u>\$</u> 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) d 2 should be filed within , th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Lucent Technologies 12 Telecommunication installer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be.
Department of Health and Mental temportant: If them 27 is more any Injury or other. Elmer Baxter Thomas, Sr. Pearl Louise Wright ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Green / Sister 7002 Wake Forest Drive, College Park, MD 20740 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery : 2/15/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 1mw /2 Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sician and burial-transit The law requires that the death certificate be executed "ulmoneAR" resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) signed by the a ☐Yes 2 No Ö 9 Unknown 9 Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗆 No 2 X No 1 ☐ Yes 1 Yes al or Attending Physician: safter death.
Il Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 🔀 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atter within 24 hours after de: To the Funeral Directo 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRECERBELT EDVER FAR KWAT Day, Year I 6 2010 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ivia	aryland / Depa Cei	tificate of L			Reg. No. 2 1 1	05873
	Physicia	n/	1. Decedent's Name (First, Middle, Las Marie Katherine		n			2. Date of Dea Month Februa		3. Time of Death 7:00 a M
-	Medic Examine	al -	la. Facility Name (if not institution, give			4b. City, Town, or	Location of Death	reprue	4c. County of Death	
	Examili	G (	Suburban Hospita			Bethe			Montgon	nery
	Funeral Director		115-10-5807	ex	(In yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April	9. Birth Cour. 12, 1915 No	nplace (State or Foreign ntry) W York
	and show dat	. t	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	//arylar 8a-f s tified	Director	Maryland Montgor	nery	Rockv	ille				1 🗆 Yes 2 🟝 No
	with the N s 23a or 2 ust be no	Funeral Di	10e. Street and Number 6624 Sulky Lane			10f. Zip Code 208			10g. Citizen of What Cou USA	intry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.	ver in U.S. 13.	Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
215-0	in 72 houre. e. Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give	dent's Usual Occup kind of work done O NOT use retired) Homemak	during most of work	ing	16b. Kind of Business I	ndustry
த Baltimore, Maryland 21215-0036	oe filed with intal Hygien ced other the sevent, the	To Be Co	17. Father's Name (First, Middle, Last) Frederick Spina			Homemax		e (First, Middle, l Casella	Maiden Surname)	
Maryl	d 2 should the alth and Me		19a. Informant's Name/Relationship (7 Adrienne Marcell						; City or Town, State, Zip	Code)
imore,	Page 1 and ment of Heitant: If item iury or othe	le is	20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)	Gate of I	eaven Cei	metery Fe	Date b. 12, 010		ing, Marylan
Batt	permit. Depart Import any inj		21. Signature of Funeral Service Licent	See Oss	Į.	Name and Address J rancis J 00 Unive	ss of Facility Collins rsity Blv	Funeral	l Home Inc. Silver Spri	ng, MD 20901
	Physician/ Medical Examiner		23a. Part 1. Enits the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line Pulmona	the death. Do not ende.  ry Edema a consequence of):	er the mode of <b>d</b> yir	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
00/		ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying		yopathy a consequence oi).					
00	cate be executed physician and s the burial-transit	al Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
200	ate be	edical		d						
Box 68	death certifi ne attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death 3	☐ Ectopic pregnan☐ Other (specify)	су		23d. Date of del Month	ivery Day Year
IS, P.O.	Attending Physician: The law requires that the redeath redeath.  sctor: After this certificate has been signed by the funeral director, page 2 should be detachly the funeral director, page 2 should be detached.	ed by Ph	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause g	iven in Part I.		obacco use contribute to Yes 2 🏲 No 3 🗆 Pi	
$\mathcal{M}_{\mathcal{A}}\mathcal{A}_{\mathcal{A}}$ Vital Records, $\dot{P}$ .0	The law req ate has bee page 2 sho	Completed by						24a. Was autor perfo 1  Yes	psy prior to or death?	topsy findings available completion of cause of
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Ot	Place of Death (Chec			
<u>=</u>	Physi rthis o	은	1 Yes 2 XNo 27. Manner of Death	1 28a. Date of inju	ient 2 ER/Outpatieury 28b. Time	of 28c. Inju	4 □ Nursing H ry at		dence 6 Other (Spec now injury occurred	ify)
7 5	nding ath. r; After re fune	icate	1 X Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		ay, Year) injury	M 1 L	k? ] Yes 2 □ No			
A to Division	I or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Inj	ury - At home, farm, s c. (Specify)	reet, factory, office		28f. Location (\$ City or Tov	Street and Number or Ru vn, State)	ral Route Number,
or	n 24 hours n 24 hours ne Funeral	Medical	(Cheek 2 Medical Even	inar On the basis of	examination and/or inve	stigation, in my opin	ion, death occurred a	at the time, date a	ause(s) and manner as sta and place, and due to the le cause(s) and manner as	cause(s) and manner stated.
=	Within comp	_	29b. Signature and title of certifie	all shu	Kospital	1 39c. Licen	se number		29d. Date signed (Month)	h, Day, Year) 10
			30. Name and address of person who Petr F. Hausner				Road, Bet	hesda,	MD 20814	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 12 20	O Penua	rar's Signature	Kal.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Month Physician/ M AOP: H Mildred L. Thompson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0015+01 S Dicomico If Under 1 Year I If Under 24 Hrs. 8. Pate of Birth 5. Social Security Number 9. Birthplace (State or Foreign MD 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 🗆 M 2 🔀 F Hours Min. 06/14/1937 215-36-3413 72 **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Merical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20601 **IISA** 11510 Acton Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Specify: White 1 Yes 2XXNo Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than 's may injury or other traumatic event, the Meany injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Admin Assist. Fed. Gov. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Kathleen Hill Thompson John Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11510 Acton Lane Waldorf, MD 20601 Cynthia Berry (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 16, 201 Waldorf. MD 4 ☐ Donation 5 ☐ Other (Specify) St Peters Cemetery Feb. 21. Sign of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St.Berlin, MD 21811 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused spock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRBAST Physician/ MALIGNANT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 7 No
9 Unknown ŏ Year Month Pregnant at time of death 5 Other (specify) , the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Z No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an autopsy perform completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? PICR Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058410 30. Name and additions of person who completed cause of death (Item 23a) (Type, Print) WHU 5 GHuyan

Registrar

State

31. Date filed (Month, Day, Year)

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NOW

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Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\angle \cup$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death W 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7/14/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 □ M 2 🕏 F NY 85 058-20-3427 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pikesville 1 Yes XX No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21208 USA 3800 Old Court Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify Specify: 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Denta1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Swist Matwey Borowetz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen Dicken Daughter Randallstown, MD 21133 9407 Jodale Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/1/2010 Odenton, MD Epiphany Cemetery 22. Name and Address of Facility Hardesty Funeral Home, 21. Signature of Funeral Service Licensee Annapolis, MD 21401 10 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meumoni Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) YOR Hospital: Other: 4 Nursing Home 5 Residence 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify, 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner executed and burial-trar Box 68760. attending physician requires that the death certificate be the as ase Por P.O. I the þ signed I Division of Vital Records, peen has page 2 certificate Hospital or Attending Physician: this After

Examine Physician/Medical ð Completed Be 2 Certification: 24 hours after death. • Funeral Director: A filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other I any injury or other traumatic event, Ih

**Physician** 

/Medical

within 72 hours after

Baltimore, Maryland 21215-0036

27. Manner of Death

4 Homicide

29a. Certifier

6 ☐ Could not be 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tit

29c. License number

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month

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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2:56P M Ε Willis Februar 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 505 Suffolk Prince Georges Ave. #302 Capitol Heights Social Security Number 8. Date of Birth (Month, Day, Sept. 1 Funeral If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 1 **X**M 2 □ F Hours **Director** <u>577-58-2177</u> 64 Yrs. 1945 Georgia Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD PG Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 Suffolk Ave., #302 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:Black Completed 3 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Warehouse Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked o မ McNeil Willis Lillie Moss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Village Green Drive Rosemary Willis/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State i = 6 1 

Burial 2 

Cremation 3 

Removal from State cemetery, crematory or other place) 2/15/10 Department of Important: If any injury or 4 Donation 5 Other (Specify) Riverdale Crematory Riverdale, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest signals, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death A theroscleratio Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Due to forces a consequence of, Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the winder. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 \$\square\$ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 💆 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) State 16 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #22 Per FH G901 3/15/2010 Jh
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ <u>:4</u>5 ам 02 10 2010 V. Whitaker Percy Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges  ${ t Clinton}$ If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth g, Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 🖾 M 2 🗆 F Months North Carolina 11 / 14 / 1939 Yrs. Director 578**-**50-7523 70 Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-1 show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 ☐ No Camp Springs Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 USA 7230 Easy Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : 2 X No 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Black. Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government College (1-4 or 5+) Elementary/Seconday (0-12) Department of Defense <u>Procurement Specialist</u> Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>John Whitaker</u> Beatrice Lee Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20748 Kevin Whitaker / Son 30 Easy Street Camp Springs, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 02/24/2010 Brentwood, MD 22. Name and Address of Facility Ft Bacon F.H.
3401 Bladensburg Funeral Home Inc. Street N.W. Wash.D.C twood, MD 20722 20010 Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death csti Physician/ ON disease or condition Medical resulting in death) **Examiner** Saquentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and ned for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cid need Iniul 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes Certificate: To 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 000616 10

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** Gwendolyn Herring Washington February 3,2010 1644 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fort Washington Prince Georges 2210 Rosecroft Blvd If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Year) Days Min. 1 □ M 2 🙀 F Months Hours 90 Jan.5,1920 NC Director 207-14-7940 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show items 23a or 28a-f shores removed to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of 1 X Yes 2 □ No Director Fort Washington MD PG the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 2210 Rosecroft Blvd 20744 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ★No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced "natural" other than "natur 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12)  $5 \pm$ Government Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental 7 Is marked of traumatic even Modie Bell ဂ္ Flovd Herring Jinkie Pearlie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosecroft Blvd Washington, Md Health : Jinkie Corbin/daughter 20744 item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/13/10 permit. Pages 1
Department of F
Important: If iter
any injury or ott 1 

Burial 2 □ Cremation 3 □ Removal from State Memorial Cemetery Mt. Olive, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 11. Enter the disease, or complications that caused the dath. Do not enter the mode of dying such as cardiac or respiratory arrest, mock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death m diate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760. Physician/Medical anding p IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No 1 ☐ Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Year Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performeg 2 🗹 No 1 □Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 D Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

State

1 6 2010

29b. Signature and title

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** b. City, Town, or Location of Death /Medical County of Death 4a. Facility Name (If not institution, give street and number, Examiner timore Homewood 8. Date of Birth (Month, Day, Mar 2, Birthplace (State or Country) If Under 1 Year | If Under 24 Hrs. Foreign unk 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ₹ M 2 □ F Màr 61 Director 214-56-1229 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Experiment is usable inclined at 1 X Yes 2 □ No Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examinar mental process. 21212 USA 6000 Bellona Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian unk 1 ∐Yes 2 XNo If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: white 2 3 Widowed 4 Divorced unk Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21212 6000 Bellona Avenue Baltimore, MD Genesis Homewood Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation_5型Qther (Specify) in state Signature of Euneral Struce Licen Wade, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Party. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause and chine. CUNCEV Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 1 ☐ Yes 2 ☐ No 4 🗌 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, 2 100 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation n 24 hours after death.

e Funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year) MAR 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) artes St. 32. Registrar's Sign sture

1000 son, MMD 21586

			_ For	State of Ma	aryland /	Depa	artment of	Health a	and M	lental Hy	giene			
		•	State Registrar			Cer	tificate of	Death			Reg. No. 2	)   0	05	880
	Physicia		1. Decedent's Name (First, Middle, Las Goddard Williams	•	ttom					2. Date of Dec Month 02/02/2		Year	3. Time of 11:36	
•	Medic Examin		4a. Facility Name (if not institution, give	street and number)		-	4b. City, Town,	or Location o		02, 02,		ty of Death		
-			Casey House				Rockvil	1e			Mont	gomer	сy	
	Funeral Director		5. Social Security Number 6. Se	ex ∏X M 2 □ F	e (In yrs. last b 80	irthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birt (Month, Date 12/15/	h ( 929	9. Birth Cou Rhoc	hplace (State o	nd
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	or 28	Director	10e. Street and Number	. L y	поск		10f. Zip Code				10g. Citizen o	f What Co		2 - 110
	h with the rs 23a c	Funeral	11913 Renwood Lar	ne			20852				Unite	d Sta	ites	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X☐ If Yes, Give Year or Dates.		lf lf	Vas Decedent of Yes, specify Cul ☐ Yes 2 🔀 N	oan, Mexican	, Puerto F		Bi	ace - Amer ack, White fy:Whit		
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Baltimore, Maryland 21215-0036	12 shoulalth and 27 is m		19a. Informant's Name/Relationship (7) Colin Winterbotto				g Address (Stree New Hamp							009
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.   ▼o the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.		23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the se	2 🗌 Fetal dea		Ectopic pregnal Other (specify)	псу				ate of delivionth		/ear
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ξ	hysic nis ce I direc	은	1 🗆 Yes 2 🔀 No	Hospital: 1  Inpatie	ent 2 ER/C	Outpatien	t 3 □ DOA Ot	her: 4 🗌 Nu	rsing Hor	ne 5 🗆 Resid	ence 6 🛛 Ot	ner (Specii	fy) Hospi	ice
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Jivisi	al or Atte s after de il Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc		farm, stre	et, factory, office		2	8f. Location (S City or Tow		er or Rura	al Route Numb	er,
_	e Hospit 124 hour e Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one) 3 Certifying Nursi	sician: To the best of a	amination and	or investi	gation, in my opir	ion, death oc	curred at	the time, date a	nd place, and d	ue to the ca	ause(s) and ma	nner stated.
	To the within comp		29b. Signature and title of certifier	tchou			29c. Licen				29d. Date sign	ed (Month,	, Day, Year)	
	1-		30. Name and address of person who c J. Kouatchou, MD	ompleted cause of de	eath (Item 23a)	(Type, Pi								· · · · · · · · · · · · · · · · · · ·
	Stat Registra	e 31. Date filed (Month, Day, Year) 32 Registrar's Signature												
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2010 00:21 William J. Ward February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** E1kton Union Hospital of Cecil County Cecil | If Under 24 Hrs. | 8. Date of Birth Hours | Min. | 8. Date of Birth (Month, Pay Year) | 33 9. Birthplace (State or Foreign CounNorth East Mary Land 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Days 1**∑** M 2□ F Months 77 Director 219-28-1470 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exyminal must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🙀 No Director Maryland Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 805 Hances Point Road 21901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Fixes 2 □ No In Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operating Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph Ward Josephine Chapman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Hances Point Road, North East, Maryland 21901 Michelle Ward / Daughter permit. Pages 1 a
Department of Her
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place)
North, East Methodist
Church Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 18, 2010 North East, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ardispulmond disease or condition resulting in death) /Medical Due to (or as a cons vuence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): arter Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy been signed by the etter should be detached for Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes : After this certific s funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 🗷 Ño 2 ☐ ER/Outpatient 3 ☐ DOA 1 npatient Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mys um

5+ | VF

Registrar

Street

Elkton MD Z1921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 6

Year)

31. Date

06

32. Registrar's Signature

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		Registrar  1. Decedent's Name (First, Middle, Last)			- 00	Timoate of L	- Catir	2. Date of De	Reg. No. 2	<del>J   U</del>	3. Time of Death
Physicia Medic		George Edward Van						Februa	ry 7, 2	2010	8:50 A ^M
Examin	er	4a. Facility Name (if not institution, give str				31	Location of Death			nty of Death	1-
Funeral		Buckingham's Cho	7. Ag	e (In yrs. las	st birthday,		If Under 24 Hrs.	8. Date of Bir	th	ederic g. Birth	place (State or Foreign
Director		098-09-1547 Usual Residence of Decedent	M 2 🗆 F	92	Yrs.	Months Days	Hours Min.	Sept 2	y, Year) 27 <b>, 1</b> 917	New	York
and show	tor	10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits
Mary 28a-f	Director	Maryland Frederic	k		P	damstown	<u>.</u>				1 🗆 Yes 2 🖵 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral	10e. Street and Number 3200 Baker Circle	Apt TO	15		10f. Zip Code <b>2171</b>	0		10g. Citizen o	of What Coul ed Sta	-
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should and M is ma auma		19a. Informant's Name/Relationship (Type	1			ling Address (Street a		al Route Numbe	r, City or Town		
and 2 Health em 27 ther tr		Jane Vanwynen Phil	lips/dau			Chestnut	Oak Driv		ersbure		
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rmit. P partm portar y injur		21. Signature of Funeral Service Licensee		LTII							
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Physician/  Medical		disease or condition resulting in death)	Due to (or as	a conseque	enge of):	tive	heart	fail	Yre		1-2 Week
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examiner									
the Hithin 24 the Formplet	Me	only one) 3 Certifying Nurse I					e time, date and pla			manner as st	ated.
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DHMH 17 Rev 7/2009

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Medic Examin	al	Gertrude Ma 4a. Facility Name (if not institu			ber)		I _{4b, C}	ty Town or	Location of De		'ebrua			2010 y of Death	1 4:12 r	<u>М</u>
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Funeral		5. Social Security Number	6. Se	ex □ M 2 <b>X</b> F	7. Age (In yrs.		Month	der 1 Year ns Days	If Under 24 H Hours Mi	in.	. Date of Bir Month, Da larch	th Year)	022	g. Birtl	hplace (State or Fo	oreign
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/land f shov ed at	tor	10a. State 10b. Co	,				or Location								10d. Inside City L	
e Man r 28a- notifie	Director	Maryland Ch	narle	5	l In	dıan	Head	7in Code							1 X Yes 2	□ No
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items	Funeral	11. Marital Status		12. Was Dece	dent Ever in U.	S.	13. Was Dec	edent of His	spanic Origin?	(Specify	y Yes or No-		14. Ra	ce - Amer	ican Indian,	
after al", or xa nir	d b	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 ☐ Yes If Yes, Give	² XNo			2 <b>X</b> No		5110 1110	ian, 0.0.,		Specify	ick, White ^{/:} Whi		
hours natura dical E	Completed	15. Dec	cedent's E		tes.	16a. D	ecedent's U	sual Occupa	ation			16b. I		Business I		
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and 2 Health em 27 ther tr	3	Raymond R. We	eks,	Jr.	son				l., Indi						F Obst.	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inmoortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Serv			<u>    11</u>	init	y Menk	orial	Gargens	3					aryland	
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tne de by the tached	hys	9 🗆 Unknown		g 🗌 Unkno						_						
es mar igned be def	<u> </u>	Part II. Other significant con	iditions co	ontributing to de	ath but not res	sulting in 1	the underlyin	g cause givi	en in Part I.		_		_	_	the cause of death	
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aing r h. After t funera	Certificate:	27. Manner of Death  1 Natural 5 Pe 2 Accident Inv			of injury h, Day, Year)	28b. Tin inju		28c. Injury work?		28d	I. Describe h	ow inju	y occuri	red		
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within To the compl	Σ	only one) 3 L Certif 29b. Signature and title of cer		e Fractioner.	o the best of th	y KHOWIEC		9c. License		piace, a					Day, Year)	
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XONG		30. Name and address of per	son who c	ompleted cause	of death (Item	23a) (Ty	oe, Print)	- PM	Quil	02	1/12 (	11.	2/21	1 172	1 11/72	3<
State	e	31. Date filed (Month, Day, Yea	ar)	32. Rg	gistrar's Signa	ture 🔏	TILL	NC	· _)(()†		1001	_ 111	1101	لللبل	1001	))
Registra			167	/010 K/	acres 1	19	BOLF	200								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For	State of Maryland				fental Hy	giene	0.1.0	05001
		-	State Registrar		Cer	tificate of L	Death		Reg. No	$U \mid U$	U 5 8 8 4
	Physicia		1. Decedent's Name (First, Middle, Last)	WAC	51)			2. Date of Dea	Day	Year WIU	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Cou	unty of Death	
e j et			3850 Enfield Ch			2 Bo	wie If Under 24 Hrs.	O Data of Bird		nce Ge	eorge place (State or Foreign
	Funeral		5. Social Security Number 6. Set	M 20 F	ast birthday) L Yrs.	Months Days	Hours Min.	8. Date of Birl (Month, Da 1 – 4 – 1	y, Year)	Cou	th Carolina
	Director	ŀ	243-24-3822 Usual Residence of Decedent	88				1-4-1	922		
	yland how		10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits 1 ☐Yes 2 ☐ No
	e Mai	Director	Maryland Prince	George B	owie	T			10 0":	-618/h =4 Cov	
	vith th		10e. Street and Number			10f. Zip Code	_			of What Cou	Intry?
	eath v	eral	3850Enfield Chas	se Court Apt 12. Was Decedent Ever in U.S	.112	2071		ecify Yes or No		JSA Race - Amer	ican Indian,
5	be filed within 72 hours after death with the Maryland Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Modest Even in a rust be notified.	y Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		Yes, specify Cuba ☐Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		Black, White, ecify:	_
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Maryland 21215-0036	be filed within 72 ho ttal Hygiene. d other than "natul event, th. III. d c al	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed)  College (1-4or 5+)	(Give I	kind of work done of OO NOT use retired	during most of work	ing			
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ē,	s 1 and 2 of Health item 27 other tr		Doris N. Hill-S 20a. Method of Disposition	lster 20b. P	lace of Dispos	wie, Mar sition (Name of natory or other place	yrand_	Date	20c. Locat	tion - City or T	
<u>o</u> E	00		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		Vetera		6/10	Chel	tenhai	m,MD
	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens			, Name and Addre			-manage -		
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П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death ne cause on each line.	n. Do not ente				arrest,		Approximate Interval Between Onset and Death
1	Physician	Ìij	Immediate Cause (Final disease or condition	a. mitastr	Ju (	a, ur	diagne	sed p	ni ma	My	Monten
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):			U			
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Box	leath certific attending p	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 □	Ectopic pregnanc	У		230	d. Date of del Month	Day Year
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σ.	that the		Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
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Division of Vital Records, P.O.	The Is	mo.						perf 1 □ Yes	ormed?	death?	2 □ No
<u>a</u>	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?	-100			26. Place of Dea	th (Check only	one)		
×	hysic this ce al dire		1 Yes 2 No		ER/Outpatier		4 LI Nursing F	ome 5 Res			cify)
n o	ing P	ü.	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k? ]Yes 2∐No	28d. Describe	how injury o	occurred	
Sic	ttend death stor:	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm str		iles Z Lino	28f. Location	(Street and I	Number or Ri	ural Route Number,
<u>&gt;</u>	after Direct	Certification: To	4 ☐ Homicide determined	building, etc. (Specif	<i>(y)</i>	, <b>,</b> ,		City or To	wn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina	owledge, deat ation and/or in	h occurred at the ti	ime, date and place opinion, death occu	e, and due to th arred at the time	e cause(s) a e, date and p	and manner a lace, and due	s stated. e to the cause(s)
	thin 2.	Medical	one)  29b. Signature and title of certifier.	and manner stated.		29c. Licens				signed (Mont	
	<b>₽</b> ₹ <b>₽</b> 8		29b. Signature and time of carmine	Flent	a w				-		
P	JBM 6		30. Name and address of person who	V- · h	n 23a) (Type,	Print) NEV	ENCE	16+11	A AN	NAPOL	08,2010
1		de.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	71 111	EIVIE	71710	. 11		- 101
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lara Denise Webster 5, 2010 February 9:04 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 1898 Uniontown Road Carroll Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 □ M 2 1 F 218-11-7667 Director 39 Yrs Dec 3, 1970 Kentucky Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23e or 28e-f show the Medical Example must be notified at 1 Yes 2 No Maryland Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1898 Uniontown Road 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No δ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "n College (1-4or 5+) 5+ Elementary/Secondary (0-12) Self Employed Interpreter Sign Language 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Oliver Brenda Ellis 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is m any injury or other treum QDCE. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Webster, husband 1898 Uniontown Road, Westminster, MD 21158 20b. Place of Disposition (Name of Church of God Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 02/12/2010 Uniontown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 تسكمد 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GLIOBLAS TOMA MUTTFORME /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 NO To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/5/10 D 43643 WE . 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) TANEULTOUN, OND 21767 12 TATE 76 Frederice 1 ASON ms. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Enwa B. park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decede nt's Mame (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BEARVAR, Medical 4a. Facility Name (if not institution, give 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MERFOR . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 X M 2 □ F Months Days Hours **Director** 76 086-26-6811 New Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Florida Po1k Bartow 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2055 S. Floral Ave., #301 33830 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify. Year or Dates. 1954-55 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Printer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William R. Aumann Florence E. Waldmeyer permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Felter/ Daughter 733 Appomattox Rd. W. Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Meml. Gdns. 2/15/10 Frederick, MD 22. Name and Address of Facility George P. Kalas Funeral Home Signatura ce Licensee 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ A disease or condition resulting in death) YPAP Medical Due to (or as a consequence of) Examine Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-trar that initiated events esulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) Yes 1 L Yes 2 L 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Be Completed 1 Yes 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy prior to completion of cause of death? page 2 2 No 25. Was case referred to 26. Place of Death (Check only one) examiner? Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury atural 5 Pending Accident Investigation Director: / Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Fractioner T. the Less I my an wild gesting the country of the flag and a country of the classes of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Fractioner T. the Less I my an wild gesting a manner of the last state of the cause (s) and a manner stated as a country of the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 15*1

State Registrar

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FEB 12

2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 05887 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catherine C. Aydinian February 2010 2:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 16806 Hoffman Manor Drive Montgomery Silver Spring Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 10, **Funeral** 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 屎 F United States ^{Year)} 1922 **Director** 090-24-9088 87 Dec Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗌 Yes 2 🖵 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Hoffman Manor Drive 20905 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. l by 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 No 1 ☐ Yes 2 X No Specify: Specify White

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any highry or other traumatic event, the Medical Examiner must be notified at
once.

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

ĕ	3 X Widowed 4 L Divorced	Year or Dates.					_		орослу.			
Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's Usual Occu (Give kind of work done	durina m	ost of working	g	16b. I	Kind of Busine	ess Indu	stry	
	Elementary/Seconday (0-12)	College (1-4 or 5+	)	life. DO NOT use retired Homemaker	1)				wn Hom	e		
Be	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name (	(First, Middle	, Maiden	Surname)			
٥	Allan Cameron				E	lizabe	th Mo	cCle	llan			
	19a. Informant's Name/Relationship (Type	e, Print)	19b	. Mailing Address (Stree						Zin Cou	de)	
A		/ 0		806 Hoffmar								-
	John R. Aydinian 20a. Method of Disposition	/ Son		Disposition (Name of	Han	Da Di i			ocation - City	<u> </u>		
	1 🔀 Burial 2 🗆 Cremation 3 🗆 R	temoval from State	cemeter	y, crematory or other pla	· .							
	4 Donation 5 Other (Specify)		Gate 0	f Heaven		Feb 1			Silver		ing, ME	)
	21. Signature of Funeral Service Licensee	•		22. Name and Addr Francis	ess of Fac	ility llins	Funera	al H	ome In	С.	- MD 06	
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused to cause on each line.  Alabein  Due to (or as a common section)	ers Do	mentia	ng, such a	S cardiac or	respiratory a	rrest,	ver sp	A Ir C	Approximate Interval Between Onset and Death Interval Service Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Bet	1
:xamıner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	Due to (or as a o										
ealcal	d d		onsequence o							$\perp$		
nysician/medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	□ Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify) _		-			23d. Date of Month	delivery Da		
7	Part II. Other significant conditions conf	tributing to death but	not resulting in	n the underlying cause g	iven in Pa	rt I.	23e. Did t	obacco	use contribute	e to the	cause of death?	,
o pa	Type II Diabetes M	ellitus					1 🗆	Yes 2	x∏No 3□	Probab	oly 4 🗆 Unkno	own
Completed	History of Colon	Cancer					24a. Was auto perfo	psy ormed?	prior death	to comp	/ findings availal	ble of
é	25. Was case referred to medical examiner?			26. F	Place of De	eath (Check o	nly one)					
2	1 ☐ Yes 2 🕱 No	ospital: 1	t 2 ER/Out	tpatient 3 DOA Oth	ner: 4 🔲 I	Nursing Home	e 5 🕱 Resi	dence (	6 Other (Sp	secify)		
Certificate:	27. Manner of Death  1   Natural  5 □ Pending  2 □ Accident Investigation  3 □ Suicide  6 □ Could not be	28a. Date of injury (Month, Day,	Year) 28b. Ti	jury wor	ry at	28	d. Describe l					
	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, fan Specify)	m, street, factory, office	_	28	If. Location (S City or Tov		nd Number or n)	Rural Ro	oute Number,	
Medical		r: On the basis of exa	mination and/or	leath occured at the time investigation, in my opin edge, death occurred at the	ion, death	occurred at th	ne time, date a	and place	e, and due to the	he cause	(s) and manner s	stated.
	29b. Signature and title of certifier			29c. Licens	se number			29d. Da	ite signed (Mo	nth, Day	, Year)	
	1 TOATA	/		D00350	045			Feb	ruary	12,	2010	
	30. Name and address of person who con	npleted cause of dea	th (Item 23a) (T	vpe, Print)								

State Registrar Philip G.

Henjum

"1"6" 2010

Prince Philip Drive #200 Olney. MD 20832

18109

David Hemandez- Andrade

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryla	nd / Department	of Health	n and	Mental	Hygiene

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		1- For State Registrar	ate of maryia		tificate of	Death			Re	g. No.	_ U   \	00000
Physicia	n/	Decedent's Name (First, Middle)		VIEN - 10					Date of Death Month	Day	Year	3. Time of Death 1255 hrs
Medical Examin	er	David  4a. Facility Name (if not institution	Alexis He			e b. City, Town, o	or Location o		ebruary 2	, 2010	inty of Death	
		University Hospital	in, give street and num	iliber)		Baltimore	or Ecodelori o	Booti			,	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye		_	. Date of Birtl	h(MM/DD/Y		hplace (State or nE1 Salvador
Director		577-33 <del>-</del> 6568	1 M 2 F		21 Yrs.	Months Da	ays Hours	Min.	May 14	, 198	8 Co	untry)
y,	-	Usual Residence of Decedent  10a. State 10b. County		10c City 1	Town or Location	on.						10d. Inside City Limits
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irs afte tural"	흵	15. Decedent's Education (Spe	or Dates:	e completed)	16a. Decedent	's Usual Occup	ation (Give k	ind of work	done		of Business/I	
72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)	during mo	st of working lif	fe. DO NOT (	use retired)				
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	ပ္က မြ	17. Father's Name (First, Middle, Julio Romero	Hernandez						rst, Middle, M Andra		ame)	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she readent traumatic event, the Medical Examiner must be notified at once	L B	19a. Informant's Name/Relations			19b. Mailing	Address (Stre					Town, State	Zip Code)
e, MD I and 2 sho Health and item 27 is traumati	ĺ	Andrea Andrad	<b>e</b> (Mot	her)		enyon S						
nore, Mages I and 2 of Health 2 other traum		20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Removal fro		lace of Disposi ematory or oth		emetery,	D	ate	20c. Locat	ion - City or	Town, State
Page ment c		4 Donation 5 Other S	ecify:		ily Cen	netery		02-19			1vado	
Baltimore, permit. Pages 1 ar Department of Hee Important: If itel injury or other tr	1	21. Signature of Funeral Service	Licensee	ca 7	100							me, Inc.
Physician	4	2 Part Enter the disease, or	complications that car	used the death.	Do not enter th	47 14th e mode of dying	g, such as ca	ardiac or re	spiratory arre	st, shock, o	r heart	Approximate Interval
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Lammer	1	or condition resulting in death)	,	consequence of)	:							
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Box 687 e death certific the attending p	ig	past 12 months?	4 Pregna	ant at time of dea	=	er (Specify)		programoy				,
Bo he deat the at hed for	Physician/		(nown 9 Unknow		tion in the		sives is De	41	220 Did tob	22000 1150 0	contribute to	the cause of death?
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Vital Rec ysician: The l his certificate l		25. Was case referred to medica				26.Plac	ce of Death (	Check only			1 7 10	3 2 10
Vita nysicia this ce	Lo Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 🗸 In	patient 2 .	ER/Outpatient	3 DOA	Other ₄	Nursing H	ome 5 F	Residence	6 Other	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death.  Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.		27. Manner of Death  1 Natural 5 Pend	28a. Date of FOUND:		28b. Time of In FOUND:		jury at Work? Yes 2 ✔	luu	d. Describe hi ng himsel		curred	
ivision I or Attend after death. Director: d in by the f	Cati	2 Accident Inves	stigation Feb 2, 26		1530 hrs				Location (St	reet and N	umber or Ru	ral Route Number, City
Divi	Certification		d not be	Jail/Penal	no, ram, saco	, (40.6)	Dunanig, oto		or Town, Sta	ate)		ter , Rockville , MD
		29a. Certifier 1 Certifying Pl	hysician: To the best									
To the Hos within 24 h To the Fun completely	Medical	2 🔻	miner:On the basis of and manner sta		d/or investigati			curred at the	e time, date a			
	Σ	29b signature and title of certific	11, 61	11.	negv		.M.E.				signed <i>(Mor</i> y 4, 2010	nth, Day, Year)
		30. Name and address of person	who completed cause	e of death (Item	23a)							
CR 3		Victor Weedn MD JD	Assistant Med			enn Street,	Baltimore	, MD 21	201			
Sta		31. Date filed (Month, Day, Year)	32 Reg	gistr 's Signatur	was							
Regist	ar	FEB 1 7 2010	Jane -	1-17								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05889 Certificate of Death

				For State Registrar	State 0	i iviai yiai		rtificate of	Death		Reg. No. 2	10	05889
		Physici	an	1. Decedent's Name (First, Middle						2. Date of Dea Month	Dav	Year	3. Time of Death
	D.	/Medic		Ollie Mae Boyd  4a. Facility Name (If not institutio		mber)	-	4b. City. Town, o	r Location of Death	Feb.	4c. County	010 of Death	06:15a ^M
1		Examin	iei	Harford Memori				Havre de			Harfo		
		Funeral		5. Social Security Number	6. Sex		. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h v. Year)		ace (State or Foreign
		Director		222-24-5471	1 □ M 2 💢 F		94 Yrs.	Monais Days	Tiodio Mini.	Oct. 2	1, 1915		VA
		and and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation		·		1(	Od. Inside City Limits
		10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City or Location   10c. City or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City or Location   10c. City or Location   10c. City or Location   10c. City or Location   10c. City or Location   10c. City or Location   10c. City or Location   1											1 ☐ Yes 2 ☑ No
		r 28a	irec	10e. Street and Number		11.2	Laing 5	10f. Zip Code			10g. Citizen of W	hat Coun	try?
		th with	a D	501 Ridge Rd.				21911			USA		
		r dea	<b>Funeral Director</b>	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	J.S. 13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	e - Americ k, White, e	
	36	, or it	by Fi	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ∐Yes If Yes, Giv	2 <b>∭</b> No ve		1 □ Yes 2 □XNo			Specify		
5	21215-0036	hour tural	ed		Year or Da	ates:	16a, Dece	dent's Usual Occup	pation	T	16b. Kind of Bu	Whi	
1	215	e. <b>n."ne</b>	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)	-4or 5+)	(Give life. I	kind of work done DO NOT use retired	during most of work d)	ing			
90	217	d with giene er tha	ĕ	Elementary/Secondary (0-12)	College (1	-401 5+)	Secr	etary			Public	Saf	ety
	pu	tal Hy d other	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle,	Maiden Surnam	e)	
	yla	ould to	ပ္	Burton Marvin					Charlot				
	Baltimore, Maryland	h and h and h and h land		19a. Informant's Name/Relations			-1	-	and Number or Rui		-	State, Zip	Code)
1/0	9	1 and Healt em 2		C. Dale Lofthou	se/ nepne				Rising S	Date	20c. Location -	City or To	wn. State
9	nor	ages ent of t: If it y or o		1 XBurial 2 ☐ Cremation		State		sition (Name of matory or other place	:			-	
03/16/10	Ħ	nit. Partme ortan Injur		4 □ Donation 5 □ Other (S		пс	22	Cemetery  Name and Addre	see of Encility				osit, MD
0	ä	Dep any any onc		XV had	L. O.	1:0	R	T. Foard	d Funeral een St. R	Home, lising Su	P.A. un. MD 2	1911	
				23a. Part 1. Enter the disease, or shock or heart failure. List	complications that conly one of use on e	aused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
4	E	Physician		Immediate Cause (Final disease or condition		FORAT		ista i	leum				Onset and Death
	1	/Medical Examiner		resulting in death)	Due to (	or as a consec	quence of):	r.					
aw		Examiner	<u>.</u>	Sequentially list conditions,				MRIVE					
, ,		ited nsit	nine	Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a consec	quence on:						
		icate be executed physician and the burial-transit	Examiner	that initiated events ' ' resulting in death) Last	cDue to (	or as a consec	quence of):					$\rightarrow$	
	68760,	se be			d.								
		± 50 %	<b>l</b> edical										
	Box	eath cer attendin for use	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		☐ Ectopic pregnanc	ev .		I	e of delive	•
	0.	e dea the at	Physician/	in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown	4 ☐ Pregr 9 ☐ Unkn	nant at time of own		Other (specify)			Мо	ntn	Day Year
	σ.	that the dended by the detached		Part II. Other significant conditi	ons contributing to de	eath but not res	sulting in the u	nderlying cause giv	ven in Part I	23e. Did to	bacco use conti	ribute to th	e cause of death?
	Records,	signe signe	l by	Tare in Outer Significant conduct	one contributing to the	saur but not re.	suiting in the di	ndenying cadse giv	ciriir arti.				ably 4 ☐ Unknown
·	Ö	w requires to be a signal should be a	Completed							24a. Was			
7	Re	e has ge 2 s	ם							autop	rmed?   c	death?	psy findings available inpletion of cause of
0		siclan: The la certificate ha rector, page?	ပ္မ	25. Was case referred to medica					26. Place of Deat	1 🗆 Yes	2 No 1	I∐Yes	2 <b>X</b> No
^	of Vital	Physiclan: this certific al director, p	o Be	examiner? 1 ☐ Yes 2 No	4	npatient 2 F	BR/Outpatier	ot 3 🗆 DOA Oth	nor:		dence 6 Oth	er (Snecifi	
7		ding Ph h. After thi funeral	اڃّا	27. Manner of Death	28a. Date		28b. Time of				now injury occurr		
20	į	Attendin death. ctor: Af y the fur	atio	1 Accident 5 ☐ Pendir investi	gation	in, Day, reary	,,		Yes 2 □No				
4	Division	or Att	rtific	3 Suicide 6 Could 4 Homicide detern	not be nined 28e. Place building	of Injury - At h ng, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Tou	Street and Numb vn, State)	er or Rura	l Route Number,
		spital	al Ce	29a. Certifier 1X Certifyii	ng Physicien: To the	best of my kn	owledge, deat	h occurred at the ti	me, date and place	, and due to the	cause(s) and ma	anner as s	tated.
		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification: To		Examiner: On the ba								
	_	Vith Vith Com	Σ	29b. Signature and title of certifie	110			29c. Licens	-1-		29d. Date signed		
4		/			141				0768		2/16	120	10
		5		30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Type,	AND HA	VTP do G	0 100	Mn 2	107	18

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) FEB 1 1 2010

			For State Registrar	State of Mary		partment of ertificate of		nd Mental Hy	giene Reg. No.	0 05890
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath	3. Time of Death
	Physicia Medic		Otho Levelle Black	well, Jr.				Februa	ry ÎO 2ŎĨ	
	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, o	or Location of D	Death	4c. County of De	eath
			1621 Millstone Dri	ve		Edgewat	er		Anne A	rundel
	Funeral		Social Security Number     6. Sex	1 · · · · · · · · · · · · · · · · · · ·	yrs. last birthda	y) If Under 1 Year Months Days			th 9. E	Birthplace (State or Foreign
	Director			^{3 M 2 □ F}   83	Yrs	. Workins Days	Hours	Min. 01/14/	1927 Was	hington, D.C.
	d tow	_	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or	Leastien		·		Transaction in the
	ırylar I-f st	읂	Maryland Anne Aru		Edgewat					10d, Inside City Limits
	e Ma r 28g	Director	10e. Street and Number							1 Yes 21 No
	ith th		1621 Millstone Dri			10f. Zip Code 21037			10g. Citizen of What	-
	ath w	Funeral		12. Was Decedent Ever i	in II S 1		Jianania Origini	? (Specify Yes or No-	United St	
(0	or ite		1 Never Married 2 Married	Armed Forces?	1 0.0.	If Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)	14. Hace - Ar Black, Wh	nerican Indian, nite, etc.
ğ	saft ral", Exal	be F	3 X Widowed 4 □ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates. 194	4-46	1 ☐ Yes 2X No	Specify:		Specify: Wh	ite
20	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad	cation	16a. De	cedent's Usual Occup	oation		16b. Kind of Busines	
7	nin 72 ne. han '	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìife	ve kind of work done DO NOT use retired,		working	Governmen	t Printing
7	ygier ygier her t		12		Supe	ervisor			Office	
<u>n</u>	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	11 0				Name (First, Middle,		
ž	should be file h and Mental I 7 is marked o raumatic eve	_	Otho Levelle Black	· · · · · · · · · · · · · · · · · · ·			DOLOCI	ny Loretta	Porten	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ) E1izabeth Joy Amat		19b. Ma	ailing Address (Street Riversid	and Numbero	r Rural Route Numbe	ir, City or Town, State, $11\mathrm{e}$ , MD $20^\circ$	Zip Code) 7.6.5
ė,	and Healt tem 2		20a. Method of Disposition			position (Name of	1			
õ	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, c	rematory or other pla		Date	20c. Location - City	
₽	artme artme ortan injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Sign ure of Fineral Service License	I ^V i	aryıand v				Crownsvill Kalas Fune:	e, Maryland
a	permit. Departr Imports any inju		W / / Z	5		2973 So1o	mons Is	sland Road	. Edgewate	r, MD 21037
			23a. Part 1. Enter the disease, or compli	cations that caused the	death. Do not e					Approximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	Em	hysema				Interval Between Onset and Death
	Medical		disease or condition resulting in death)	. Due to (or as a con		The second				
	Examiner		Sequentially list conditions h							
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):					
	cutec	хап	that initiated events	. =						1
	be executed sician and burial-transi	alE	resulting in death) Last	Due to (or as a con	isequence or):					
760	phy:	edical	d							
8	certificate inding physuse as the	Σ	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome of pre	egnancy				20   5   1	
ROX	death o	iciai	in the past 12 months?	1 Live Birth 2 4 Pregnant at time		☐ Ectopic pregnand ☐ Other (specify)	ру		23d. Date of d Month	Day Year
S. E	v requires that the death certific been signed by the attending should be detached for use as	Physician/M	g Unknown	9 Unknown						
7.	that I	by P	Part II. Other significant conditions con	tributing to death but no	t resulting in the	e underlying cause gi	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Š	uires in sign							1 🗆 '	Yes 2□No 3🛣	Probably 4 🗆 Unknown
Vital Records,	w req s bee	Completed						24a. Was a	an 24b. Were a	utopsy findings available
ě	he la	E O						— autop perfo 1 ☐ Yes	rmed? death?	o completion of cause of
<u>=</u>	ian: T		25. Was case referred to medical examiner?			26. Pl	ace of Death (0	Check only one)	Z ANO I L T	es 2 LJ NO
=	nysic lis ce direc	19	1 ☐ Yes 2 🖾 No	ospital:	2  ER/Outpat	ient 3 DOA Oth	er: 4 🗆 Nursir	na Home 5 🗓 Resid	lence 6  Other (Spe	ecify)
0	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yea	28b. Time		v at		ow injury occurred	
<u></u>	tendi leath. or: A the fu	iţica	2 Accident Investigation 3 Suicide 6 Could not be			M 1 □	Yes 2 No	·		
DIVISION OF	or At	Certificate:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, s ec <i>ify)</i>	street, factory, office		28f. Location (S City or Tow	street and Number or R rn, State)	ural Route Number,
5	pital ours a eral [		29a. Certifier 1 Certifying Physic	ian: To the best of my ki	novelodgo, doot	h accurad at the time	data and size			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medical Examine	r: On the basis of examin	ation and/or inv	estigation, in my opinio	on, death occur	red at the time, date a	nd place, and due to the	cause(s) and manner stated
	To th Withir	2	29b. Signature and title of certifier	R. / D.	or triy tallowloage	29c. License	number	d place, and due to the	29d. Date signed (Mon	
			Spend	bear 100		D	46052	-	29d. Date signed (Mon	
	6 10	Ì	30. Name and address of person who cor	npleted cause of death (	Item 23a) (Type	Print) Da. L.	0.	abolio Ma	)	
			of Part fled in it is	FU 2001	Mean	ne minim	, min	Lew 110	<u> </u>	
	Stat Registra	e r	29b. Signature and title of certifier  30. Name and address of person who core beach,  31. Date filed (Month, Day Year)  FEB 1 2 2	32. Registrar's Si	gnature A.	back				
				- John Tone		1				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or Pri						•		Legibl	e.	
		For State		State of M	arylan	•				lental Hy	giene	201	0	05001
		Registrar  1. Decedent's Name	/Finat Adiabala	Loot		Cer	tificate of	Death	1		Reg. No.	401	U	05891
Physicia	n/		a E. Be	,						2. Date of De Feb 13		O Yea	ır	3. Time of Death 16:55 M
Medic Examin				give street and number)			4b. City, Town,	or Locatio	n of Death	TED 13	<del></del>	County of D	eath	10.55
LAGIIII	· ·			and Hospita	1			into				-		rge's
Funeral		5. Social Security No		6. Sex 7. Ag		st birthday)	If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Bir		9.	Birthpl Co <i>untr</i>	ace (State or Foreign
Director		420 62 Usual Residence of		1 □ M 2 TF	61	Yrs.				Sept 2.	2, 19	48 A	lab	ama
and show dat	tor	10a. State	10b. County		10c. City	, Town or Loc	ation		-				10	d. Inside City Limits
Mary 28a-f otifie	irec	MD	P.0			Cli	nton						_L	1 ☐ Yes 2XX No
filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f show svent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Num		el Drive			10f. Zip Code	20735	5			en of What ted S		
ath wi	nue	11. Marital Status	riichae	12. Was Decedent	Ever in U.S	13 V	Vas Decedent of			cify Yes or No-		4. Race - A		
ter de or ite minel	by F	1 Never Marri	ed 2 Marri	Armed Forces?			Vas Decedent of Yes, specify Cu			Rican, etc.)	'	Black, W	hite, et	c.
urs af :ural", al Exa		3 Widowed		Year or Dates.		1	☐ Yes 2 🔀 N	lo Speci	ify:		S	pecify:	W	hite 
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within jiene.	Cor	Elementary/Second 12	onday (0-12)	College (1-4 or 9	5+)		iget Ana	,			Fe	deral	Go	vernment
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should be and Ment is marker aumatic e	To	Otis		ephenson		1			Inez					
2 shorth and the and the and the and the traun		19a. Informant's Na		_{p (Type, Print)} , Jr. (Husba	nd)		g Address (Stree						Zip Co	ide)
1 and f Heal item 2		20a. Method of Disp	osition		20b. P	lace of Dispos	sition (Name of		_	Date	•	ation - City	or Tow	/n, State
Page ment o ant: If ury or		1 ☐ Burial 2X 4 ☐ Donation	XCremation 5 ☐ Other (Sp	3 ☐ Removal from State pecify)	Le		atory or other $p_i$		2010					yland
permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		21. Signature of Fun	neral Service Li	1 11/			Name and Add lexandri			Funera				
9.0 E # 9		Mas	10U	-	1001							, MD	20	735
<b>D</b>		shock, or hear Immediate Cause (F	t failure. List or	complications that caused ly one cause on each line	the death	n. Do not ente	r the mode of dy		2	r respiratory ari	)	C		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)		Due to for as	a consequ	ence of):	ere (	ence	ere V	Bull	7110	JCan	1	Londonion
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rtificat ling ph e as th	Physician/Medica	IF FEMALE:		000 15000 0000000										
ath ce attend for us	cian	23b. Was decedent   in the past 12 n 1 Yes 2		23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	death 3 🗌	Ectopic pregna Other (specify)	ncy			23	ld. Date of Month		y Day Year
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s that gned k	by P	Part II. Other signifi	cant condition	s contributing to death b	ut not resu	ulting in the ur	nderlying cause	given in Pa	rt 1.	23e. Did to	obacco use	contribute	to the	cause of death?
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n: The ficate or, pag		25. Was case referre	nd to medical					DI( D		1 🗆 Yes	rmed? 2 No			□ No
/sicial s certi	To Be	examiner?	No	Hospital:	ent 2 🗆	ER/Outpatient	_ [0	her:	eath (Check	me 5 Resid	longo 6	Othor (Sp	o o if d	
ng Phy ter thi		27. Manne of Death	5 Pending	28a. Date of inju	ry	28b. Time of injury	28c. Inju			28d. Describe h			eciry)	
tendii Jeath. tor: Ai the fu	Certificate:	2 Accident 3 Suicide	Investiga	ation			M 1	Yes 2	□ No		_			
l or At after o Direct		4  Homicide	determin				et, factory, office		1	28f. Location (S City or Tow		lumber or l	Rural F	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier	Certifying I	hysician: To the best of	mv knowle	edge, death o	ccured at the tin	ne, date an	d place, and	d due to the cau	use(s) and	manner as:	stated.	
the Ho hin 24 the Fu			Certifying I	aminer: On the basis of e Nurse Practions: To the	xamination best of my	and/or investi- knowledge, de	eath occurred at	the time, da	ate and place	e, and due to the	e cause(s) a	nd manner	as stat	ed.
viti Sor		29b. Signature and	itle of certific	MA				se number	-1			signed (Mo		
0.0	ŀ	30, Name and addre	ss of person w	o completed cause of d	eath (Item	23a) (Type: Pr	-		7	) 2	(1)	with the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of t	121	15/2010
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	1 _ State	State of Mar	-		of Healtl		-	_	7111		058	92	
-	Registrar  1. Decedent's Name (First, Middle, Last)		0.6		or Deal	111	2. Date of De	Reg. No.			B. Time of Deat	h	
ın	Robert M F	Bradsho	311)				Month	Day	7 Year		1042 A		
al er	4a. Facility Name (If not institution, give str	<u>.</u>	100	4b. City, T	own, or Location	on of Death		4c.	County of Dea		1		
36	Anne Arundel M	ed Ctr		An	napoli	5		1/	mne A	rur	relel		
	5. Social Security Number 6. Sex		In yrs. last birthda		Year If Und	der 24 Hrs.	8. Date of Bir (Month, Da		9. Bir	thplace	(State or Fore	eign	
	216-27-17/8	VI 2□F	Yrs.				1/24	1/39	Mary				
	Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or	Location				-		10d.	Inside City Lin	nits	
Ö	Maryland Queen Ar			XXYes 2□	No								
rec	10e. Street and Number	ine	Queensto	10f. Zip 0	Code			10g. Citizen of What Country?					
a D	112 Taylor Drive			2	1658			USA					
ner		. Was Decedent Eve Armed Forces?	er in U.S. 13			Origin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit		Indian,		
y Fu	1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give		1 Yes 2			r nodri, oto.)		Specify: Wh				
D D	3 Widowed 4 Divorced	Year or Dates:	16a Das					105 K					
olete	15. Decedent's Educa (Specify only highest grade of	completed)	(Gin	edent's Usual /e kind of work . DO NOT use	done durina r	nost of worki	ing	16D. KI	nd of Business	/inaust	try		
mo	Elementary/Secondary (0-12) 9 th.	College (1-4or 5+)		Farmer	,			Far	rmina				
o Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)			T W T III C T		other's Name	(First, Middle						
0 E	Solis F. Bradshaw				Venr	n V. B	rown						
	19a. Informant's Name/Relationship (Type	. Print)	19b. Ma	iling Address (	Street and Nu	mber or Rura	al Route Numb	er, City o	r Town, State, .	Zip Co	de)		
	Kathryn Bradshaw/ Wi	fe	112	Taylor	<u>Drive</u>				yland 2				
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Ren	noval from State	20b. Place of Dis cemetery, ci	rematory or oth	e of her place)		Date	20c. Lo	ecation - City or	Town,	State		
	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Dicensele		Trinity	Mem. Ga	rdens Address of Fa	Feb. 1	8, 201	0_Wa	ldorf,	Mar	yland		
	XI. Signature of Currenal Service Exerises	L MBI				· пи	ntt Fur			20/	201		
	23a. Part1. Enter the disease, or compli a	tions that caused th							f, MD.	Ap	proximate		
	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	DALAGE	+ A	TGO	y >		15		Or	erval Between set and Death	1	
	disease or condition resulting in death)	Due to (or as a c	consequence of):	1 ne	-1124	10	- ラモ コ	512	_	-			
	Sequentially list conditions.  b. HYPGPTENSTON												
iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):											
xam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	A3E	N=9	WE	LLI	145						
dical Examiner		1+4	PERC	400	£57	GRE	J. G F	1+1	1-				
Σ	IF FEMALE: 23b. Was decedent pregnant 23c	tf yes, outcome pf 1□Live birth 2	pregnancy	B∐Ectopic pre				1/2	23d. Date of de	livery			
Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tin		☐ Other (spe					Month	Da	y Year		
Phy	9 Unknown												
þ	Part II. Other significant conditions contri	buting to death but r	not resulting in the	underlying cal	use given in Pa	art I.	23e. Dia 1		ise contribute to No 3 □ P		ause of death: y 4 ∐Unkno		
eted	1												
mp							24a. Was auto		24b. Were at prior to death?	utopsy comple	findings availa etion of cause	able of	
	25. Was case referred to medical				00.5		1□ Yes	2 No	1 ☐ Yes	2 2	No		
To Be	examiner?	spital:	2  ER/Outpati	ent 3□ DOA	Other:		n (Check only o		6 □Other (Spe	noifu)			
	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time		c. Injury at Work?		28d. Describe			спу)			
atio	1 ♣ Natural 5 Pending 2 Accident investigation	(month, bay )	out) Injury	М	1 ☐ Yes 2	No							
ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (	- At home, farm, s (Specify)	street, factory,	office	1	28f. Location ( City or To		d Number or R	ural Ro	oute Number,		
Ö	One Continue of El Contifuing Discussion	Jan. Ta the best of			A 46 - 12 1 - 1								
Medical Certification:	29a. Certifier (Check only one)  1	r: On the basis of exant manner state	xamination and/or	ath occurred a investigation, i	it the time, date in my opinion,	e and place, death occurr	and due to the red at the time,	cause(s) , date and	and manner a d place, and du	s state e to the	d. e cause(s)		
Me	29b. Signature and title of certifier	N A	( >	29c.	License numb	er		29d. Da	te signed (Moni	th, Day	, Year)		
	1 2 mck	( y me	e K.Mi	1 I	>35	048	3	2	2/12	17	010	)	
	30. Name and address of person who com				, ,					+			
	Dr. Cinganic, 629 Ra			erville	MD.	21617						X	
e ar	31. Date filed (Month, Day, Year) FEB 17 201	32. Registrar's		backer	8								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ S. Brewington Merbruary ay9, 2010 10:57 a_M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15311 Beaverbrook Court, #2G Silver Spring Mon topomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🏻 F Hours May 8, 1937 D.C. 578-48-2234 72 Director Usual Residence of Deceden 28a-f shov ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗗 No Maryland Mon topmery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 15311 Beaverbrook Court, #2G 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify Completed 3X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Bookkeeper Bookkeeping Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jesse Sowell Diko Charlotte 19a. Informant's Name/Relationship (Type, Print) Philip R. H. Connor, III/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Park Avenue, 10th Floor, New York, NY 10065 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11, Feb. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, VA 21. Signatur of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, tus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Heart Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): executed Cause (Disease or imjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year detached the Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 K Probably 4 ☐ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? certificate 2 🗆 No 1 🗌 Yes Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, E

Day, Year)

d cause of death (Item 23a) (Type Print)
Shady Grove Road, Rockville, MD 20833

NI

who **1499**5

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		Registrar  1. Decedent's Name (First, Middle,	Last)		Cei	inicale or	Death	2. Date of Dea	Reg. No.	3. Time of Death		
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Exam		4a. Facility Name (If not institution,	-	nber)		4b. City, Town, o	r Location of Dea		4c. County of Death			
		Wilson Health		7 Ann //n /	a a de finale al a co	Gaithersburg  If Under 1 Year   If Under 24 Hrs.   8. Date of			Montgomery			
Funera Director		5. Social Security Number 233–34–6383	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I: 85	Yrs.	Months Days	Hours Min	. (Month, Day		Birthplace (State or Foreign Country)		
Topic see		Usual Residence of Decedent						03/14/	1924  We	st Virginia		
arylan show d at	_	MD 10b. County Montgo	maru		, Town or Loc	cation				10d. Inside City Limits		
he Ma 18a-f s otifie	Director		шегу	FOL	omac	1				1X Yes 2 No		
with t	ä	10e. Street and Number 13728 Canal Vi	eta Court			10f. Zip Code 20854			10g. Citizen of Wha	•		
death ms 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13. V		Hispanic Origin? (	Specify Yes or No- rto Rican, etc.)	United St 14. Race - A	American Indian,		
c, Inicity facility A 12.13-0030 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Fem 27 is marked other than "natural", or items 23a or 28a-f show when traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 【 Widowed 4 ☐ Divorced	Armed Fo ed 1 ☐ Yes If Yes, Giv Year or Da	2 <b>∑</b> No ⁄e		Yes, specify Cub	Specify:	rto Hican, etc.)	Specify:	White, etc. White		
72 ho	Completed	15. Decedent' (Specify only highest	s Education t grade completed)		16a. Deced	ent's Usual Occup	oation during most of wo d)	orking I	16b. Kind of Busine	ess/Industry		
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<b>₹</b> √₽ ≤		Barbara Ann Bogg	gs / Daug				Vista Co		nac, MD 20			
Pages 1 Tent of H Int: If iter		20a. Method of Disposition 1   Burial 2 □ Cremation		State CE	emetery, cren	sition (Name of natory or other pla	· ·	Date	20c. Location - City			
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permit. Departr Importa		11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	Muna	1					shington,			
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Phys er this eral dir	5	1 Yes 2 No 27. Manper of Death	28a. Date		28b. Time of	28c. Inju	4 Nursing		lence 6 Other (	Specify)		
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (		examiner: On the b						cause(s) and manne date and place, and	er as stated. due to the cause(s)		
To th withir To th	Me	29b. Signature and title of certifier	tul	) ohn	<u> </u>	29c. Licens			Februar			
		30. Name and address of person			23a) (Type,	Print)	-11 A		1	9 Md.		
47		31 Data filed (Month Day Year)	J olinsky	egistrar's Signat	711	160381	en Hve	2. 621	thersbur	9 Md.		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🏻 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lillian February 11, 2010 В. Bowen 11:15 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-30-1296 1 □ M 2 🖳 F Months Days Maynth 1889, Year)913 96 Marvland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Brookeville 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 19109 Georgia Avenue 20833 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify "natural", Specify. 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) giene. Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Retail l Hygie other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H ၉ Granville L. Berry Blanche Dove traumatic 19a. Informant's Name/Relationship (*Type, Print*) George W. Lonas/Son ess (Street and Number or Rural Route Number, City or Town, State, Zip Code, 83rd Court, Gainesville, FL 32607 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 any injury or or Date 18, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 20c. Location - City or Town, State Feb. 2010 4 Donation 5 Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Atrial Fibrillation Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dehydration Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Sepsis and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 XNo the g Unknown g 🗌 Unknown signed by the P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw has page performe or Attending Physician: The certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 2 ☐ No Other: 1 Tes 2 1 ₺ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 X Natural s after death.

I Director: Aft of in by the fur Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hin 24 hours af the Funeral D mpleted filled i Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 100 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 65305 February 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Khan Farhat, MD 1500 Forest Glen Road, Silver Spring, MD 20910 Day Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Februar Year Edna Bernard Mary 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4412 Samar Street Beltsville Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/25/1931 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F none 78 Director India Usual Residence of Decedent the Maryland 10a, State 10b. County 10c City Town or Location show 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the medical Evancines must be notified at Chennai Director none Villivakkam 1√Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 37-59B Seeyalam First Street 600049 India death Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: 2 Specify: Asian 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Teacher 12 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Pereira Rita unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Sabrina Roberts/Daughter 4412 Samar Street Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 Demoval from State Kilpauk Cemetery 2/22/2010 4 □ Donation 5 ☐ Other (Speoff Chennai, India 21. Signature of Funeral Servi PHITTIPADOS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a ArterioscheroTic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed buriai-transi Exami and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 1 ☐Yes 2 ☑No 9 ☐ Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy Hospital or Attending Physician: The certificate performed Division of Vital 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) DAWGREEN examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 6 Other (Specify funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 5 ☐ Pending investigation 1-Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year

FEB 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

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29c. License number

29d. Date signed (Month, Day, Year)

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			1 - For State Registrar	State of Maryland		rtment of F		and Me		giene Reg. No. 20	10	05897
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05898 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year Arthur Scott Barncord 2010 Medical February 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown Mary's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours Min (Month, Day, Ye **Director** 218-60-0605 1952 Marvland Usual Residence of Decedent fshov filed within 72 hours after death with the Maryland al Hygiene. 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD St. Mary California 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23244 Chestnut Oak Court, Apt.1071 20619 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. 1X Yes 2 ☐ No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Specify: Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Driver Furniture Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Scott Barncord Nina Loeber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Barncord/Former Spouse 11632 Wollaston Circle, Swann Point, MD 20645 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Brinsfield-Echols Crem. 2/15/10 4 Donation 5 Other (Specify) Charlotte Hall,MD 21. Signature of Funeral Service Licensee M00945 Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. CU Mary's La Plata, MD Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) tata Medical Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 9 Unknown 2 🗌 No ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig ; page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 10 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 1 Natural injury 5 Pending 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) BBILL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Velyn Marie FEBRUARY 12 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
JULY 23, 1919 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. 213-03-1264 90 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Directo 1 ☐ Yes 2 No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 TERRAPIN GROVE, APT 315 21666 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any hiury or other traumatic event, In-1 once. SEWING 12 BOOKKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ERNEST T. ZIEGLER ANNA MAE LANG 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DREW COURT, BALDWIN, MARYLAND 21013 ERNEST BRUFF/SON 20a. Method of Disposition 20c. Location - City or Town, State FEBRUARY 17 1 ■ Burial 2 □ Cremation 3 □ Removal from State STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 2010 21. Signature of Euneral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rontal Tempora pariela /Medical Due to (or as a consequence of Examiner fibrill Se uentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performed 1 ☐Yes 2 No 1 ☐Yes 2 ☐No i 24 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

TH

State Registrar Medical

Partingy

Jumay MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amois MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n 5 9 0 0 1 - State Registrar Certificate of Death 1. Dededent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 5 2010 Dorvar 750 M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death . County of Death Washington Hagerstown Washington County Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign 1 □ M 2√□ Months 219-20-1660 Director 88 MD -15-192 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Washington Boonsboro 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8507 Mapleville Road 21713 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) aircraft mfg.co. Elementary/Seconday (0-12) College (1-4 or 5+) food preparation 9th grade Be 17. Father's Name (First, Middle, Last)
David Samuel Trumpower 18. Mother's Name (First, Middle, Maiden Surname) Grace Slayman 19a. Informant's Name/Relationship (Type, Print) daughter Sandra J.Hovermale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19504 Thomas Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb Date 3. MD Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cedar Lawn Cem. Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, 310 Clear Spring, MD O.BOX 23a. Part 1/ Enter the disease, or complications that valued shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not ter the mode of dying, such as car liad or respiratory arrest, Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical ce of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a conseque Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month ed by the a detached f 9 Unknown 9 Unknown P.O. signed to Part II. Other eignificant conditions contributing ng in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🗌 No 1 Yes director, 25. Was case referred to e Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. this Certificate: 27, Manner of Date of injury 28c. Injury at work?
1 ☐ Yes 2 ☑ No 28b. Time of 28d. Describe how injury occurred 1 Uniural injury 5 Pending rau Accident Investigation UNK 3 Suicide 6 Could not be jury - At home, farm, street, factory, office etc. (Specify) 28f. Location (Street and Number or Rural Route Number O City or Town, State) determined ildin Keed 8501 mapieville Rd Boonsboroo - NUrsing Home Medical Certifying Physician. To the best of my inbuledge, death ocured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ☐ Medical Examiner: On the basis of ex Amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a stated. only one Certifying Nurse Practioner: To M 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februar Pay 16 2010 Evelyn Garnetta Basford Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🕮 F Months Hours Min. 08/29/1929 214-28-0260 80 Director MD Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits MD Washington Hagerstown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 Jefferson Street 21740 US ural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ottany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ David P. Bowers Hattie Lee Skelton 19a. Informant's Name/Relationship (Type, Print) William G. Basford / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zie 2019) 507 Jefferson Street, Hagestown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Lawn Mem Park 02/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home Signature of Funeral Service Lice 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between 2 / 1/2
Onset and Death Immediate Cause (Final MYOCAMPIAL IN FARCTION Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner TRS PERTENTION Sequentially list conditions, Examine (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit IMBETES Due to (or as a consequence of): resulting in death) Last the attending physician the drian the burian Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal uea 4 ☐ Pregnant at time of death Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ be Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen DYSLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an the Hospital or Attending Physician; The law this certificate has page 2 autopsy perform Yes 2 V : After this certifications and director, p Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Tes 2 No 1 Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending death. Accident 1 Yes 2 No within 24 hours after death To the Funeral Director: completed filled in by the Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0064911

State Registrar DHMH 17 Rev 7/2009

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BOULLAH, MD 1500 LENN AR HARERSTONN-MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAM MAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05902 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Barnaby **Physician** Year Betty 1440PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖸 F 62 Yrs Director 579-58-7712 Pender, NC 28, 1947 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show MD Prince George's 1t√ Yes 2 No Director Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Modical Evan man must be any injury or other traumatic event, the Modical Evan man must be any once. 12008 Chesterton Drive 20774 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 2 1 ☐ Yes 2 K No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Investigator DC Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grant Faison ပ Mary Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy A. Barnaby - Husband 12008 Chesterton Drive, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/20/2010 Wallace, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) Iron Mine Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Culm **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) WID DUUS3709 Pru 1211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonie MD 20713 tox lane STE # 2/0 14300 Gallar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Y25/0 02 Robert L. Birch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1 Hospice Wicomico at If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year -22-1940 1 XM 2 □ F Months Days Hours Min. **Director** Yrs. 230-50-3682 69 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Wicomico Pittsville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 35123 Wango Road 21850 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Schoo1 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Grayson Birch Evelyn Crowley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Julia Birch – Wife</u> <u>35123 Wango Road, Pittsville, Maryland 21850</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-2010 Springhill Memory Gds Hebron, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ MBTASTATIO COLDIN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transf and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No Certificate: To Be Completed 3 Probably 4 Unknown To the Funeral Director: After this certificate has been s completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?-Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO05 8410

Registrar

DHMH 17 Rev 7/2009

State

- Hunsun

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOR

32. Degistrar's Signature

WAN

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State State Registrar	nai yiailu /	•	tificate of L	Death		eg. No.	
	Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Deat     Month		3 Time of Death
	/Media	al		alhoun		Al- Oit Tour	l	Month 2	14 201	
إر	Examir	er	4a. Facility Name (If not institution, give street and numbe Laurelwood Care Cente			Elk	Location of Death		4c. County of Dea	itn
	Funeral		<b>5</b> 7 M 0 7 F	Age (In yrs. last t		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 5 – 1 7 – 1	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	80	Yrs.			5-17-1	929 De	laware
	ırytancı show	_	10a. State 10b. County	10c. City, To		ation				10d. Inside City Limits
	the Ma 28a-f	ecto	DE Kent  10e. Street and Number	Dove	er	10f. Zip Code		1.4	0g. Citizen of What C	1X Yes 2 No
	3a or	<b>Funeral Director</b>	430 Kings Hwy. Apt. (	209		1990	01	[ '	USA	ound y?
	tems term	nuer	11. Marital Status 12. Was Deceder Armed Forces	3?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by F	1 ☐ Never Married 2 ☐ Married 1 █ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 █ Divorced Year or Dates			□Yes 2 <b>∏K</b> No	Specify:		Specify: W	
Maryland 21215-0036	72 ho "natur	Completed by	15. Decedent's Education (Specify only highest grade completed)	16	a. Decede	ent's Usual Occupa	ation luring most of worki	ing	16b. Kind of Business	/Industry
212	within jiene. r than	ошо	Elementary/Secondary (0-12) College (1-4or	· 5+) C		enter	)		Constru	ction
pu	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			
ryla	d Ment d Ment narked natic e	To Be	Cecil James Calhour					Mason		
Ma	nd 2 st alth an 27 is r r traur		19a. Informant's Name/Relationship (Type. Print) Diana Peters/Daughter						; City or Town, State, MD 219	
Baltimore,	es 1 a of He of item or othe		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place cemei	of Disposi tery, crema	ition (Name of atory or other place	9)	Date	20c. Location - City or	Town, State
ij	it. Pag rtment rtant: I		4 Donation 5 Other (Specify)	Del.		Mem.Cen		2-2010	Bear, D	
Bal	Depa Impo any i		21. Signature of Funeral Service Licensee						neral Ho ming,DE	me,Inc. 19934
			23a. Part 1. Enter the disease, of complications that cause shock, or heart failure. List only one cause on each	ed the death. Do	not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	E-S	25					Onset and Death
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	pe tis	iner	cause Enter Underlyin	s a consequence	e of):				<u> </u>	
	execution and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or a	s a consequence	e of):					
68760,	rificate be executed ng physician and as the burial-transit	Medical E	d							
		Med	IF FEMALE:							
Вох	leath cer attendir I for use	Physician/		e of pregnancy 2  Fetal deat at time of death		Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
P.O.	at the c by the tached	hysi	9 Unknown 9 Unknown							
ls,	The faw requires that the death ce ate has been signed by the attendi	þ	Part II. Other significant conditions contributing to death	but not resulting	in the und	lerlying cause give	n in Part i.			o the cause of death?
COL	w requir s been si should I	letec						24a. Was ar		utopsy findings available
	The fav ate has bage 2 :	Completed						autops perform	y prior to ned? death?	completion of cause of
Vita	hysician: The la	Be	25. Was case referred to medical examiner?				26. Place of Death			- 1
ō	Phys er this eral dir	٦. 1	27. Manner of Death 28a. Date of In	tient 2 ☐ ER/C jury 28b.	Time of	3 ☐ DOA Othe	4 LXINursing Ho		ence 6 Other (Sperior occurred)	ecify)
ion	ending sath. or: Afte	atio	1 Natural 5 Pending (Month, C 2 Accident investigation	ay, Year)	Injury	M 1 □ Y	?			
Division of Vital Records,	or Atter de Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Ir building, €	njury - At home, f etc. <i>(Specify)</i>	farm, stree	et, factory, office		28f. Location (Sti City or Town	reet and Number or F n, State)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p		29a. Certifier (Check only 2   Medical Examiner: On the basis	t of my knowled	ge, death	occurred at the tim	ne, date and place,	and due to the ca	ause(s) and manner a	as stated.
	the Hi thin 24 the Fi	Medical	one) and manner s	tated.	and/or inve					
	0 <b>4</b> ₹ 5		29b. Signature and title of certifier			29c. License	7 3	25	9d. Date signed (Mon	un, pay, rear)
		-	30. Name and address of person who completed cause of	death (Item 23a	) (Type, P	rint)			, /	DE19)13
			Acron Store, mo 31. Date filed (Month, Day, Year) 32. Regis	CYE C	ピンソン	man D	2 Sult	e 100	NEWSKI	- DE19)13
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05905 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02/08 2010 Year Robert Allen Campbell, Sr. 0700 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22425 Hood Lane Leonardtown St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral Birthplace (State or Foreign Country) 8. Date of Birth 1 **X**XM 2 □ F Months Days Hours Min 0970571914 579-07-5533 Director 95 DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. Cify, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD St. Mary's Leonardtown 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 23a Funeral 20650 22425 Hood Lane or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give White "natural" 3 ☐XWidowed 4 ☐ Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) Line Foreman C&P Telephone Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Lacy Campbell Florence Pauline Ruddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Scott Campbell/Son 22425 Hood Lane, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Morven Cemetery 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Morven, NC 02/14/2010 . Signature Funeral Senfice Licenses 22. Name and Address of FacilityLee Funeral Home Calvert, P.A. Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CONGESTIUE HEART FAILURE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal dea in the past 12 months?
1 Yes 2 No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VASCULAR DISEASE Completed 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5  $\square$  Pending Accident 1 Tes 2 🗆 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Goldman Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) D40370 MD

State Registrar

Jew

DHMH 17 Rev 7/2009

Peter L. Wisniewski, M.D. CIMG, 110 Hospital Drive, Suite 310 Prince Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16

FEB

32. Registra s Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 20TO 6:00 A M Matthew Calvin. Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert North Beach 3904 1st Street Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Hours 02-15-1935 Mary Tand Director 212-66-3069 54 Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No North Beach MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3904 1st Street 20714 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 3. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō Black, White, etc. Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ₺ No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natur ury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hayes Calvin, Sr. Catherine Dolores Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Calvin Slater/ Daughter 25 Merino Court, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 D Burial 2 dd Cremation 3 D Removal from State Important: If any injury or 4 Donation 5 Other (Specify) Metropolitan Crematory 02/18/2010 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Physician, disease or condition resulting in death) 1 rente Medical Due to (or as a consequence of): Examiner Ne tastat 16 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death 1 Yes 2 9 Unknown 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this court. 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 잍 1 Inpatient 2 ER/Outpatient 3 IDCA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature/and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person wh ted cause of death (Item 23a) (Type, Print) dru)

DHMH 17 Rev 7/2009

State

Registrar

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FEB

31. Date filed (Month, Day, Year)

MD

ellen

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 2 Year ORTER 11:40 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1**∑** M 2 □ F 214-52-8572 58 Decth, 299 Year 951 Mary land Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29 West Washington St. Apt 210 21401 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2X Married þ Maryland 21215-0036 than "natural", 1 ☐ Yes 2X No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Black Completed Specify: Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working z should be filed within 7 th and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th O Car Detailing Toyota Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Carter Edyth Mobray permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia Ann Carter (Wife) 7895 Tall Pines Ct. Glen Burnie, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/12/10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Wm. Reese & S
821 West St. 21. Signature of Funeral Service Licenses Larry Sons ons Mortuary, Annapolis, Md M. Reen MOOY8 23a. Part 1. Enterwhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition omos Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) TATE HOUSE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Mgnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type

DHMH 17 Rev 7/2009

Registrar

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1	Funeral Director	1	579-48-1425	Sex 1 ☑ M 2 □ F 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birt 934	hplace (State or Foreign buntry) D.C
	and and		Usual Residence of Decedent  10a. State 10b. County	100	: City, Town or Lo	ocation				10d. Inside City Limits
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ä	Depar Impore eny ir		Khylle D	Blujosc						DC 20020
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a con	ntia esequence of):					Interval Between Onset and Death
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ion of	ine ine	ation; To	27. Manner of Death  1 Autural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injur	y at	ome 5 ☐ Hesiden 28d. Describe how	ce 6 □Other (Spec rinjury occurred	iny)
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pr	3		30. Name and address of person who		Item 23a) (Type, I	Print) Infton MA	Mylons	/ Wilter	FEWUM T. TANK	adn
	Sta Registr		31. Date filed (Month, Day, Year)	2010 32. Registrars Si	gnature .	and		N III I	1 - 1 - 1 - 1	,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 Day Physician/ Month 2010 JAN. 7:50 $P^{M}$ YVETTE WOOD CARTER ADRIENNEMedical 4b. City, Town, or Location of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death PRINCE GEORGE SOUTHERN MARYLAND HOSPITAL CTR. CLINTON 7. Age (In yrs. last birthday) 52 yrs 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 226-70-2407 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, Year) AUG. 7, 1957 VIRGINIA Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10d. Inside City Limits 10c. City. Town or Location Director MARYLAND PRINCE GEORGE CLINTON 1 Tes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be **Funeral** 6824 PURPLE LILAC LANE 20735 U.S.A.12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Was Deceson... Armed Forces? ¹ ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc δ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: BLACK If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DEPARTMENT OF NAVY BUDGET ANALYST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည SOUIRE WOOD CELESTE FORTUNE 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONY CARTER (HUSBAND) 6824 PURPLE LILAC LANE CLINTON, MD 20735 any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 5,2010 SHILOH BAPT. CHURCH FEB. REEDVILLE, VIRGINIA ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility 6784 MARYBALL RD BERRY O. WADDY FUNERAL HOME LANCASTER, VA 22503 Part 1. Enter the shock, or heart f isease, or complications that caused the ilure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Fir Onset and Death Metastatic Briast Physician/ unk now disease or condition Medical resulting in death) Due to (or as a o insequence of) Examiner 47K1627 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Examin Due to (or as a consequence of) nding physician use as the burial Physician/Medical use 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed certificate 2 🗓 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Plesidence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 1 Tyes 2 🔀 No ည 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 $\square$ Pending work? Accident Suicide 2 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Box 68760 P.0. Records, Hospital or Attending Physician: of Vital Division s after death. completed filled in by 24 hours a within 2 To the 1

Maryland 21215-0036

Baltimore,

D4344 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapalis Road Suite 312 Glenn de MD 20769 FARAHIEAR M.D. 12150

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

1.29.10

29c. License number

State Registrar 29a. Certifier

only one) 29b. Signature and title of certifier

Roita

M.D.

Amend Item 17 per dtr., g912,02717/2011dhb.

Amend Items 201,62717/2011dhb.

Amend Items 201,6,c per 111, g906,0870392010dhb Mental Hygiene 2 | | | For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Cleary Day Timothy Finbarr 2010 6:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 5709 Cheshire Drive Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 👿 M 2 🗆 F Months Days Hours Min. b9//30//1925 IreTand Director 84 Yrs. 075-18-0759 Usual Residence of Decedent Show 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Bethesda MD Montgomery 1 Tyes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20814 5709 Cheshire Drive 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 1 X Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 □ No 1943-Specify: White 1 ☐ Yes 2 x No Specify: Completed 3 Divorced 1945 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Occupational Safety and (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. the Health Review Commission Commissioner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evo ဂ John Francis Cleary Nora Riordan Joseph Cleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5709 Cheshire Drive Bethesda, MD 20814 Patricia Cleary / Spouse 20c. Location - City or Town, State 20a. Method of Disposition Falls Church, 20b. Place of Disposition (Name of TEDurial 2 X Cremation 3 - Removal from State National Crematory 08/06/2010 4 ☐ Donation 5 ☐ Other (Specify) Nat. Cemet . Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Metastatic Melanoma Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗵 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2X No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗓 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu le of ce 29c. License number 29d. Date signed (Month, Day, Year) 02/08/2010 D26437 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven A. Burka MD 5530 Wisconsin Ave. #914 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) . Registrar's Signature FEB 16 Registrar

DHMH 17 Rev 7/2009

State Registrar

ORIGINAL

2010

4c. County of Death

4:44 A

Montgomery

9. Birthplace (State or Foreign

Chile

10d. Inside City Limits 1 Yes 2 X No

10g. Citizen of What Country?

Chile

14. Race - American Indian, Black, White, etc.

White 16b. Kind of Business Industry

World Bank Group

18. Mother's Name (First, Middle, Maiden Surname)

9600 Weathered Oak Court Bethesda, MD. 20817

20c. Location - City or Town, State Alexandria, Virgin<u>ia</u>

22. Name and Address of Facility DeVol Funeral Home,

10 East Deer Park Drive, Gaithersburg, MD 20877

Approximate Interval Between Onset and Death

23d. Date of delivery Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Year

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D0063195 February 12, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Wilks M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
 Evora 2. Date of Death 3. Time of Death Deloris Caudle Physician Month 2010 - Delores Feb 5 1627 Candle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 241 62 5624 70 Director April24,1939 N. Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Experience must be notified at Director 1 ☐ Yes 2 ☐ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4432 G. Street #12 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or ite 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify. Black þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th <u> Homemaker</u> Private Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked of traumatic even Ira Mann Bessie Bryant ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20747 Ellis Caudle/son 5803 Marlboro Pike #302 District Heights,MD : If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2-17-2010 Suitland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fatal Cardiac Arrhythmia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 🙀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) y⊟Yes 2 No 1 ☐ Inpatient 2☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

H

State 31. Date filed (Month, Day, Year)

Griffin Davis, M.D.

Pay, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

D63688

3001 Hospital Drive Cheverly, MD 20785

February 17,2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene on the

			For State Registrar	Otate of Mi	ii yidii o		tificate of		a Meritar 11	Reg. No.	2010	05913
	Dharainia		1. Decedent's Name (First, Middle, Las	it)					2. Date of Do Month	Day	Year	3. Time of Death
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1	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o		eath	4c. C	Charles	,
-			Charles County  5. Social Security Number 6. S		ome e (In yrs. ia	et hirthday)	La P1		Hrs. 8 Date of Bi	rth		
ı	Funeral Director		214-28-4416	M 2√ F 7. A9	93	Yrs.	Months Days		Hrs. 8. Date of Bi Min. (Month, D May 13	, Year) , 191	6 Cour	lace (State or Foreign htry) Iaryland
	yland <b>how</b>		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	e Ma 3a-f s	Director	MD Charle	es	La	Plata						1 X Yes 2 □ No
	ift to	Dire	10e. Street and Number				10f. Zip Code	,		J	en of What Cour	ntry?
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21215-0036	be filed within 72 hours after death with the Maryland rial Hygiene. ad other than "natural", or items 23a or 28a-f show event, I'm findfell Erac, I'm right of a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1	≝verin U.S. √io		was Decement of F f Yes, specify Cub 1 □Yes 2 X No	Specify:	? (Specify Yes or Nuerto Rican, etc.)		Black, White,	
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$\mathbf{\Xi}$	12 m		Joan Dent/Daughter			P.O.	Box 275,	Brvan	town MD	20617		
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Baltimore,	permit. Pages 1 Department of the Important: If Ite any injury or of once.		21. Signature of Funeral Service Licer	Ehol MO	0945				FUNERAL H Ave. La P			16
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.							Approximate Interval Between
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P.O.	that the by detact		Part II. Other significant conditions of					ven in Part I.	23e. Dio	tobacco us	se contribute to t	he cause of death?
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0 0	ng Pl (fter tl inera	.:uo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Time o Injury	Wo		28d. Describe	e how injury	occurred /	
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	nil		<i>K</i>	Sindhu	, C		Do	0616	14	Feb	runy	15th, 2010
	300		30. Name and address of person who	•								
	. 6		R. Sindhwani,M.D	. 6 Post	Offic	e Road	l, Waldor	f,MD	20602			

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Day Year) FEB 18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05914 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **FEBRUARY** 12:45 PM SANDRA JEAN COOPER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 205 BRYANTOWN LANDING ROAD **OUEENSTOWN OUEEN ANNE'S** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. Director MARYLAND 216-50-3012 61 1948 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 🗶 No MARYLAND QUEEN_ANNE'S **QUEENSTOWN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 BRYANTOWN LANDING ROAD 21658 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗶 No If Yes, Give Completed by 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည AUGUSTA EUGENE POCKLINGTON STELLA VIRGINIA MOON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL ANTHONY COOPER, SR/SPOUSE 205 BRYANTOWN LANDING ROAD, QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place)

MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State FEBRUARY 18 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 GLEN BURNIE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ myourried interction Acuta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical death certificate be the attending pl IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Pregnant at time of death in the past 12 months?

1 Yes 2 No Month 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ back 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ٥ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural
2 Accident To the Hospina. ... within 24 hours after death.

To the Funeral Director: After a funeral director of the Funeral Director. (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier (Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 02-HARMS - 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALLITY 21666 DRIVE STEVENSULLE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FFR 16

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February A. Cook 20Î8 9:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Forest Heights Examiner 4c. County of Death Prince George's 5814 Ottawa Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | December 12,1938 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 530-22-2476 1 □ M 2 ⋤ F Louisiana 71 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Prince George's Forest Heights 1 Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? Funeral 5814 Ottawa Street 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XX No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: Black "natural", Specify: 3XX Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Homemaker In Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis Minor Elnora McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur C. Cook / Son 5814 Ottawa Street Forest Heights, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2/25/2010 Arlington Nat'l. Cemetery Arlington, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Go rge F. Kalas Funeral Fore, P.A. Signature F neral Service Licensee 6160 Oxon Hill Rd., Oxon Hill Maryland 20745 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Vear Pregnant at time of death 9 Unknown Unknown า signed by tl Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy OPI performed? Director: After this certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 Natural 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours after To the Funeral Dire Medical 29a Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ME 820 28 son who completed cause of death (tem 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) FEB 1 7 2010

32. Registrar's Signature

			Pleas	e Type or Pri						-		•		
		For State Registrar		State of Ma	arylan		epartme <i>Certifica</i>			Mental F	lygiene Reg. No	7011	05	916
Physicia /Medica		1. Decedent's Name		Aline			Car			2. Date of Month 2	Da	2010	3. Time 2:46	Р.,
Examine Funeral Director	er		adow Bri	dge Road Sex 7. Ag	e (In yrs. 87	last birtho Yrs	fay) If Und	den er 1 Year	If Under 24 Hrs Hours Min.	8. Date of (Month,		C		or Foreign
iryland show	_	Usual Residence of 10a. State	Decedent 10b. County			y, Town o	r Location						10d. Inside	•
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Irs after death w	by Funeral	11. Marital Status	ied 2□ Married	dge Road  12. Was Decedent Armed Forces? 1   Yes 2   If Yes, Give Year or Dates:		S.	13. Was Dec If Yes, sp 1 ☐ Yes	edent of Hecify Cub	822 dispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or to Rican, etc.)	No-	USA  14. Race - American Black, White Specify: W	e, etc.	
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and 2 should salth and Me 27 is mark er traumation	<u>۵</u>	19a. Informant's Na	ame/Relationship			19b. M	ailing Addre	·	Mattie _{and Number or Ri} ridge Roa	ural Route Nui		or Town, State,		r
t. Pages 1 at timent of He tant; If iten		4 Donation	☐ Cremation 3 5 ☐ Other (Spe				sposition (No crematory or iill Me	em. G	ds. 2-1	Date 7-2010		ocation - City or bron, M		i
Permi Depar Imbo any it		23a. Part1. Enter the shock, or heal Immediate Cause disease or condition	he disease, or contract failure. List on	ensee  populications that caused liv one cause on each liv	I the death	n. Do not	705 E	. Mai	in Street	, Sali	sbury	al Home , <u>Mary</u> l	and 213 Approxima	ate etween
Medical Examiner prize and prize transit prize transit	dical Examiner	resulting in death)  Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nditions, imediate rlying injury	Due to (or as b. Due to (or as c. Due to (or as d.	a consequ	uence of):	on's		llmi	vtr)	9		40	41)
ath ce	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12, 1 □ Yes 2,0 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 - Fetal	death	3 🗆 Ectopic 5 🗆 Other (		ey .		-	23d. Date of de Month	livery Day	Year
w requires that the de been signed by the a should be detached f	≥	Part II. Other signif	ficant conditions	s contributing to death be	ut not resu	ulting in th	e underlying	cause giv	en in Part I.		d tobacco	use contribute t	_	death? Unknown
The law the has bage 2 s	Completed									24a. W au pe 1 □Ye	topsy rformed?	prior to	utopsy finding completion of	s available cause of
sician; The certificate rector, pag	Re	25. Was case referrexaminer?	/	Hospital:				Oth	26. Place of Dea					
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification: 10	1 Yes 2 2 27. Manner of Death    27. Manner of Death    2 Natural   2  Accident		28a. Date of Inju	ry	28b. Tim Inju		28c. Injui Wor	y at	28d. Describ		6 □ Other (Sperry occurred	ecify)	
ital or Atte	Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	ed 28e. Place of inju- building, etc	c. (Specify	<i>(</i> )				City or	Town, State			mber,
thin 24 hour thin 24 hour the Funer mpletely file	Medical	29a. Certifier (Check only one)  29b. Signature and	2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	t examinat	wledge, d tion and/c	rinvestigatio	on, in my o	opinion, death occu	e, and due to turred at the tin	ne, date an	d place, and du	e to the cause	(s)
3		1 Am	ng	a completed course of d	<i>V</i>	ND	) [	228	988			ite signed (Moni	()	
84		30. Name and addre	enth	o completed cause of d	101		PO	CON	ndice n	nd	318	M		
State Registra		31. Date filed (Mont	th, Day, Year) B 1 6 20	3. Registra	ar's Signat	ure	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chesko Stephen Robert 0510 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death NI COMICO Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 **X** M 2 □ F Months Hours Min. 184-26-9529 0511011935 Director 74 Pennsylvania Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Maryland Wicomico Hebron 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21830 USA 26604 Bluejay Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 

✓ Yes 2 

No Black, White, etc. 1 Never Married 2 X Married ģ white If Yes, Give AirForce and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) technician bio medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be find of Health and Mental it item 27 is marked Mary Yambor Michael Chesko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Chesko spouse 26604 Bluejay Lane, Hebron, MD 21830 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 🙀 Cremation 3 🗌 Removal from State Salisbury Crematory 2|16|10 Salisbury, MD 4 Donation 5 Other (Specify) re of Funeral Service Licensee 241619664969FUMETral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Composi CFSP 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final HEROSCLERATIC CARDIOV Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day detached 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Completed 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**X** No 1 Yes ပ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifle 41,44 60515

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

mD

100 E. CARROLL St. SAlisbury Md. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ihimm ARAYAPPA

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**Thomas Bradley Crockett** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)
Thomas Bradley Crockett Month Day February 14, 2010 0928 hrs dical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico 30485 Zion Road Salisbury If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign ⊘oingorinia 52 Months Days Hours Director 212-72-1741 1^X M 2 F 05|15|1957 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show Maryland Wicomico Salisbury item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30485 Zion Road 21804 USA 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify. white ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nate
Injury or other traumatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) captain tugboat Father's Name (First, Middle, Last) Howard Douglas Crockett 18.Mother's Name (First, Middle, Maiden Surname)
Elizabeth Jane Crockett Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Anna Crockett Burt daughter 704 Buckingham Circle, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Crockett Family 2 20 2010 Tangier, VA 4 Donation 5 Other Specify Comotory and Address Facility al Home Professional Association 501 Snow Hill Rd., Salisbury MD 21804

Approximate Interval 21. Signature of Funeral Service Licens Approximate Interval 2 a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death Acute Alcohol Intoxication Immediate Cause (Final disease **⊀** Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed cal AMENDED 23a, 27, 28a-f per me g901 3-25-10 vt **X** UNPENDED attending physician for use as the burial of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. φ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has perform<u>ed</u>? death? ✓ Yes 2 No 1 🗸 Yes certificate 25. Was case referred to medical 26.Place of Death (Check only one) æ Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other Scene ER/Outpatient 3 DOA this 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: 1 Natural Division 1 Yes 2 X No Director: Pending 2-14-10 9:15 am unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be (Specify) house within 24 hours a To the Funeral I 30485 Zion Rd. Salisbury, Md. 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 15, 2010 hell MOMPHE. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mooth, Day, Year) 32. Registrar's Signature State

Registrar

2010

10-01056 Horace Cook Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 15919

lorace cook		1-For State Registrar Certific	eate of Death	Reg. I	2010	00010
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month Da		3. Time of Death
Medical Exami	ner	Horace James Cook	4th City Town and applies of D	February 5, 2	2010 4c. County of Death	1905 hrs
		4a. Facility Name (if not institution, give street and number) 5402 15th Avenue	4b. City, Town, or Location of D Hyattsville	eatri	Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir			MM/DD/YYYY) 9. Birti	
Director		578-64-8826 1 X M 2 F 63  Usual Residence of Decedent	Yrs. Months Days Hours	Sept. 7	, 1946 Cou	^{intry)} Florida
s ny		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	ō	Maryland Prince George's	Hyattsvil			1 Yes 2 No
ith the Maryland 23a or 28a-f she	Director	10e. Street and Number 5402 15th Avenue	10f. Zip Code 20782	10g.	Citizen of What Coun	
0036 within 72 hours after death with the Maryland giene. rer than "natural", or items 23a or 28a-f she Medical Ex rainer must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		United St	can Indian, Black,
r death	Funeral	1 X Yes 2 No		erto Alcari, etc.)	White, etc. Af r	
ırs afte ural",	<u>\$</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 X No specify:  Decedent's Usual Occupation (Give kind	of work done 16	Specify: Ame	erican
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21215-0036 ould be filed within 72 hour: d Mental Hygiene. s marked other than "matu ite event, the Medical Ex m	ادہ	17. Father's Name (First, Middle, Last)  Horace Cook	18.Mother's N	ame (First, Middle, Maid Carrie Je	, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	
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MD id 2 sho ilth and m 27 is aumati		Darryl A. Cook/ Son		apitol Heig		
S lan f Hea			of Disposition (Name of cemetery, tory or other place)	Date 20 ebruary	Oc. Location - City or	Town, State
Baltimore, permit. Pages 1 as Department of He. Important: If ite		4 Donation 5 Other Specify: Le	ee's Crematory 1	7, 2010	Clinton,	Maryland _
Balti permit. Departr Import injury		Signature of Foresta Springs are see	22. Name and Address of Facility S 4001 Benning Rd.			1nc. 20019
Physician		23a Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.	ot enter the mode of dying, such as cardi	ac or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner	- 2	Immediate Cause (Final disease a. Diabetic ketoaci	dosis			Death
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ox 68760, eath certificate be executed attending physician and for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pre		23d. Date of delivery Month D	ay Year
lox 6 eath cer eatherdi	Physician/	4 Pregnant at time of death	5 Other (Specify)			
<b>ထ</b> နို့ အ	Phy	- Journal of the lower	ng in the underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of cleath?
ires that the signed by	d b			1 Yes 2	No 3 Proba	ably 4 Unknown
ords w requires been should	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Recol The law cate has	omo			performed 1 <b>V</b> Yes 2		s 2 No
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ion of tending Pheath. tor: After the funeral	tion:	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No		,,	
0 4 5 2 3	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, f	arm, street, factory, office building, etc.	28f. Location (Stree or Town, State		al Route Number, City
Divis ospital or At hours after d ineral Direct y filled in by	Cert	4 Homicide determined (Specify)		or rown, state	,	
Divi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) Medical Examiner: On the basis of examination and/or				
To t with To t	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		d Date signed (Mon	
		May The Vale	O.C.M.E.	F	ebruary 7, 2010	
0		30. Name and address of person who completed cause of death (Item 23a)			···	
		Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore, M	ID 21201		
Sta	ate	31. Date filed (Month, Day, Year)  32. Registra's Signature				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 18 per FH/DVR G905 //22/10 dk
State of Maryland Department of John Mental Hygiene
Amend Item 23aPt1 per NP,8901e03/1601bh and Mental Hygiene
Certificate of Death
Reg. No. 20 | ( 1 - For State Registrar Reg. No. 2010 05920 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16 2^{Year} 10 **Physician** 1:01 AM February Charles W. Dolby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing & Rehab. Center Berlin Worcester If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 ☑ M 2 ☐ F 94 1, Maryland 219-03-3582 May 1915 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any injury or other traumatic event, the Menter and process. 10d. Inside City Limits 10h County 10c, City, Town or Location 10a State 1 ☐ Yes 2√ No Director MD Caroline Federalsburg 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21632 United States 4646 Preston Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. M∑MYes 2 ☐ No If Yes, Give I Year or Dates: 1 Never Married 2 Married Dolby, Charles Baltimore, Maryland 21215-0036 41-45 1 ☐ Yes 2 🛛 No Specify: White þ 3 Vidowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Motor Rebuilders Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Cannon Lunice-Katherine-Mays John Dolby ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Alejandro/Granddaughter 7959 Jones Hastings Road, Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern Sh. Veterans | 02/19/10 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom, Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 Milla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Senile Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence off Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, cate has been signi page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No certificate 1 ☐ Yes 2 ☐ No Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this ō 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after deatl To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) CRA and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Healthway DR., Berlin , MD 2/8/1 9715 32. Regetrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

0592 State of Maryland / Department of Health and Mental Hygien [ Certificate of Death 2. Dete of Deeth 3. Time of Death Month **Physician** /Medical Town, or Location of Deeth 4c. County of D Fecility Name (If not institution, give street end number) Examiner 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) 6. Sex Age (In yrs. Jest birthday) 5. Social Security Number **Funeral** Days 1□ M 2 7 215-01 Yrs Director Usuel Residence of Decedent City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 Ves 2 □ No by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Wes Decedent Ever in U,S Armed Forces? 11. Marital Status Black, White, etc. 2 NO 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last, 19b. Mailing Address (Street and Number of Rurel Route Number, City or Town, State, Zip Code) EX IZO SUNSET BLVD , PRESTON MO

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location 19e. Informant's Name/Relationship (Type, JOANNE HATCHETT 20c. Location - City or Town, State 20a. Method of Disposition ō Department of Important: If it any injury or conference of the page. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAMSON FUNDRAL HOME
3115. MAINST. FEDERALSBURG, MD 21632 Funeral Service Licensee 21. Signature 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Be Completed by Physician/Medical Examiner igned by the ettending physician and be detached for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown EROTIC CARDIOVASCULAR 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? is certificate has been si director, page 2 should this certificate has 2 No 1 ☐ Yes 2 No 1 Tes 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4□ Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To nours efter death.

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2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature end title of certifie who completed cause of death (Item 23e) (Type_Print)

State Registrar

32. Registrar's Signeture

BLOOMINGSTR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	ıryland		rtment of H tificate of D			giene Reg. No. 2 (	010	05922
Dhariai	an/	1. Decedent's Name (First, Middle, La	ist)					2. Date of Dea		Vear	3. Time of Death
Physici Med			Lee Ditma	rs	Sr.			Februa	<u> </u>	2010	10:00 A M
Exami	ner	4a. Facility Name (if not institution, giv				4b. City, Town, or				y of Death .lvert	
Funera		8822 Lafayette D 5. Social Security Number 6.		(In yrs. last	birthday)	Owings If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	place (State or Foreign	
Director			1 🕅 M 2 □ F	68	Yrs.	Months Days	Hours Min.	04-13-	1941	i., D.C.	
d low		Usual Residence of Decedent  10a, State 10b, County		10c City T	fown or Loc	eation				1	10d. Inside City Limits
arylan a-f sh fied a	sc	MD Calver		100. 011, 1	10 W 11 O 1 2 O C	Owings					1 ☐ Yes 2 🎛 No
he Mi or 28 e noti	ä	10e. Street and Number	L j			10f. Zip Code	-		10g. Citizen of	What Coul	ntry?
with t	Funeral Director	8822 Lafayette D	rive			20736			U	SA	
death item:		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - Americ	
after after xamii	qp	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 🕅 Yes 2 🗆 t If Yes, Give Year or Dates.		. 1	☐ Yes 2 🗓 No	Specify:		Specify		
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3 Widowed 4 Divorced Year or Dates. 1963–66  15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  12  Secondary (0-12)  Printer								ng			
ygien ygien her th		12		<u></u>	Prin	ter					vernment
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altimore, rmit. Page 1 and partment of Hea portant: If item y injury or other		4 Donation 5 Other (Spec			Vetera	ans Cemet	ery 02-23		Chelter		
Baltimo permit. Page Department i Important: It any injury or		21. Signature of Funeral Service Lice	P. Car			Name and Address 325 Mt. H				-	
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ox 68760 ath certificate be executed attending physician and for use as the burial-transit	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnancy	,		23d. Da	ate of deliv	ery
Box 68 death certific he attending led for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at			Other (specify)	-		М	onth	Day Year
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ding F ding F h. After funer	Sate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati	28a. Date of injur (Month, Day,	Year)	8b. Time of injury	28c. Injury work? M 1 🗆	Yes 2 No	28d. Describe h	ow injury occur	red	
Division of Vital Records, P.O. all or Attending Physician: The law requires that the safter death.  In Director. After this certificate has been signed by the funeral director, page 2 should be detach.	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Inju		e, farm, stre			28f. Location (S City or Tow		per or Rura	I Route Number,
Div iital or urs aftu ral Dir lled in											
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Example (Check 2 Medical Example )	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination a	nd/or invest	igation, in my opinio	n, death occurred at	the time, date a	nd place, and du	ue to the ca	use(s) and manner stated.
To the vithir To the comp	2	29b. Signature and title of certifier	1		3=, 0	29c. License			29d. Date signe		
		Show A 1801	Englas			Da	6358		FEB	. 12	2010
DEN 971		30. Name and address of person who	Completed cause of de	eath (Item 2	3a) (Type, P	rint)	REDERIC	ELA	11) - 2	067	P
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	s Signatur	e <b>f</b>	farkel					
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dr	Physicia		- State Registrar  1. Decedent's Name (First, Middle, Last)  2 a m s 1 Å	Deratu	Cer	tificate of		2. Date of Dea	Reg. No. 2 ( ath 2/08 2/09/20	7 10 1 <del>0</del> (ear	05923 3. Time of Death
	Medio Examin		4a. Facility Name (if no institution, give stree Calvert County Nu	at and number)		4b. City, Town, o	or Location of Death ce Freder:		(	y of Death Calve	rt
	Funeral Director		5. Social Security Number 579−18−1650  6. Sex 1	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	9/1/924	9. Birthp Coun	place (State or Foreign try) DC
	Maryland 28a-f show otified at	rector	10a. State MD Calvert	10c. City,	Town or Lo	_{cation} Dunkirk				1	0d. Inside City Limits 1 ☐ Yes 2 No
	with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Number 3120 Ashwood Driv	e		10f. Zip Code	20754		10g. Citizen of	What Cour	Ary?
920	1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1  Never Married 2  Married  3  WWidowed 4  Divorced	Was Decedent Ever in U.S. Armed Forces? 1 □ X Yes 2 □ No If Yes, Give Year or Dates.		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🗓 No	Hispanic Origin? (Spean, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ack, White, y: W	
21215-0036	vithin 72 hou iene. sr than "natu the Medica	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occu kind of work done O NOT use retired Carpente	during most of work ()	ing	16b. Kind of E	Business In	
Maryland 2	d be filed v Jental Hyg arked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Raymond Herbert I	)eCatur			18. Mother's Nam Kathl	ne (First, Middle, een Eln	Maiden Surnan ora Har	ne) ringt	on
	1 and 2 should of Health and N item 27 is me		19a. Informant's Name/Relationship (Type, Peggy Bekavac/Dau	ighter	3120	Ashwood	and Number or Rur Drive, D		MD 207	54	
Baltimore,	permit, Page 1 ar Department of Hi Important: If iten any injury or oth once.		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State Ce	metery, crei ithern		1 Gd 02/1		20c. Location	rk, M	ID
Balt	permit Depart Impor any in		21. Significant of Funeral Solid Licensee Lisa Mounts 23a. Part 1. Enter the disease, or complica			125 Sout	ess of Facility Lee hern Md B	TAGE A	MITHER.	Calve MD 20	rt, P.A.
Į	Physician/ Medical		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c. Immediate Cause (Final disease or condition resulting in death)	auco on oach lino	Ob		hit Pu	4	^	1-11	Interval Between Onset and Death
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0	be executed sician and burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or irinjury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):						
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23c 3b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	If yes, outcome of pregnar  1  Live Birth 2  Fetal  4  Pregnant at time of d 9  Unknown	death 3	Ectopic pregna Other (specify)	ncy			Date of deliv	rery Day Year
of Vital Records, P.O.	uires that the n signed by ald be detac	ρ	Part II. Other significant conditions contri	buting to death but not resu	ulting in the	underlying cause (	given in Part I.			_	he cause of death?
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Division	al or Atter s after des l Director d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)	me, farm, st	reet, factory, office		28f. Location ( City or Tou		ber or Rura	al Route Number,
u	ne Hospit: n 24 hour: ne Funera pleted fille	Medical	Charle 0 Medical Evaminer	an: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or inve	stination in my oni	nion, death occurred	at the time, date :	and place, and d	due to the ca	ause(s) and manner stated
	To # withi To #		29b. Signature and title of confider			0	006194	7	29d. Date sign	led (Month,	Day, Year)
I	RN 3		30. Name and address of person who com Manoj Mathur, M.	pleted cause of death (Item D. 110 Hospi	23a) (Type, tal Ro	Print) Dad, Suit	e 305, Pr	rince Fr	ederick	c, MD	20678
	Sta Regist		31. Date filed (Month, Day, Year) FEB 16	32. Registrats Signat		Sauce	8		<u></u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician/ Februa John Frederick Davis 201 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SALISBUI HICOMICO If Under 1 Year If Under 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** Country) 1 🛛 M 2 🗆 F Hours 87 8/29/1922 337-14-0010 Director Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Worcester Snow Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Mumford St. 21863 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status d Forces? Black, White, etc. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Forester Forestry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Nan Fredstrom Ray Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 206 Mumford St., Snow Hill, MD 21863 Margaret Davis / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 2/15/2010 Frankford, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signatu ers Service Licensee 108 WIlliam St. Berlin. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer lock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CARDIOMYOPATHY Physician/ EARS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SCV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and I for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 1 ☐ Yes 2 ☐ No certificate within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗹 No Other: 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

⊅H 15+1 State

Registrar

31. Date filed (Month, Day, Year,

FEB 16

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carol Malloy Dorsey February  $^{\mathrm{D}}$ 3, 2010 11:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 500 Castleford Street Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Days (Month, Day, Yes 52 Min. Hours **Director** 213-78-1601 Washington. Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Montgomery Rockville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Castleford Street 20851 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Document Imagery Elementary/Seconday (0-12) College (1-4 or 5+) Controller Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Thomas Joseph Malloy Joan Eichorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard C. Dorsey (Spouse) 500 Castleford Street, Rockville, MD 20851 20a. Method of Disposition 20b. Place of Disposition (Name of Feb.  $^{\text{Date}}$ 8. 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven
Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Silver Spring, Maryland Signature of ral Se DeVol Funeral Home, vice 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 rupe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart-failure. List only one cause on each line. 23a. Par 1. En shook, or h Interval Between Immediate Course (Final Onset and Death Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, tami 039190 February 15, 2010 address of person who completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed completed comp of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

J, Garrett Reilly, M.D.,

16

2010

31. Date filed (Month, Day, Year)

3418 Olanwood Court, #111, Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Teath State Registra AMEND#7perFH, 2/16/10, BMW, Moc Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 13, 2010 de la Hoz Physician/ Heme1 Alvarez 11:15am Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Country) Colombia 1 X M 2 □ F Months Hours Min. 4 MMB PT 930 579-84-9734 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director MD Montgomery Silver Spring 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 813 Heron Drive Colombia 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black White etc. þ 1 Never Married 2 K Married 1 X Yes 2 No Specificolombian Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Airlines Mechanic 8 d 2 should be filed with alth and Mental Hygien 27 is marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Ana Maria de la Hoz Manuel Alvarez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Nulfa Solano/Wife 813 Heron Drive Silver Spring, Md 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 K Removal from State Soledad Atlantico, Central Cemetery 2/22/2010 4 Donatio 5 Other (Specify) Colombia.S.A PHINTP ADERINALDI FUNERAL SERVICE, P.A. Funeral Service 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Lung Cancer
Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Yes 2 ☐ No been signed by the should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s perform 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔀 No or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Property of the funeral Director. 5 Pending 1 🔀 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R115108 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

Muncaster Mill Rd Rockville Md.

6001

CRNP

Diane Ruckert

16

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 2010 6:15 Peter Carl Daub Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 🖾 M 2 🗆 F 0272171926 83 Germany Director 090-32-8574 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2X No Maryland Montgomery Garrett Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral with 11308 Kenilworth Avenue 20896 Germany/Austria 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Owner and President Steel and Metal Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Erwin Daub Margareta Zinn 1 and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11308 Kenilworth Avenue Garrett Park, MD. 20896 Christina Daub (Daughter) t; If item 2 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot Feb. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan C<u>rematory</u> Alexandria, Virginia 2010 Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, Part 1. E ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate cause (Final Physician/ di r condition resulting in death) Acute Respiratory Failure Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Line to for as a pursecuence of and -transit requires that the death certificate be executed Acute Renal Failure that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24a. Was an Were autopsy findings available prior to completion of cause of Atrial Fibrillation Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has k cate has t autopsy performe death? 1 ☐ Yes 2 ☐XNo Yes 2 X No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 XNo 1 Yes မ 1 🛮 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MD D0065505 February 09, 2010

DHMH 17 Rev 7/2009

State Registrar 9901 Medical Center Drive Rockville, MD. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra

Qiufang Cheng M.D.

31. Date filed (Month, Day, Year) FEB 16

3. Time of Death

3:17 PM

1 Yes 2X No

CHESTER

Approximate Onset and Death

Day

FEBRUARY 12, 2010

Year

Box 68760 P.O. Records, Division of Vital within 2

> State Registrar

31. Date filed (Month, Day, Year

anula

SAMUEL M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIBBER, M.D., 200 FORBES STREET, STE. 200, ANNAPOLIS, MARYLAND 21401 2. Registrar's Signature

**b**18381

State of Maryland / Department of Health and Mental Hygiene 2 05929 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2:20 A DONALD JACK DILWORTH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 □ F Days Hours July 18,1931 West Virginia 78 214-28-0599 Director Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral USA 21740 17326 Gay Street Was Decedent Lys. Armed Forces? 195. XX Yes 2 No 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, 1952-Black, White, etc. 1 Never Married 2 WMarried þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Truck Manufacturing Driller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Virgil Dilworth Dortha Lois Phillips other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is 1 Hagerstown, MD 21740 Marjorie L. Dilworth - Wife 17326 Gay Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 02-16-2010 Smithsburg, Maryland 4 Donation Other (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A 21. Signature of Funeral Serv Williamsport, MD 21795 425 S. Conococheague St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death CARDIO PULMOMARY Immediate Cause (Final ARREST Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner OLON CANCER Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown P.0. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No has page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Hospital or Attending Physician: **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 110 ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After ompleted filled in by the fun 2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death baccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 77P8 3000 Feb. 16th, 2010 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H 3+1 Shoaib 400 W 7th St Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State FEB 17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 6, Physician/ 10:40 PM William A. Driskill 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert-Burnett Hospice House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 X M 2 □ F 1913 Charlotte County, VA 96 223-09-1697 March Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Calvert Owings 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20736 USA 1041 Concord Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No ģ Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates White Specify. "natural", Completed 3 X Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) je 1 and 2 should be filed within 72 t of Health and Mental Hygiene.

If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Construction Foreman 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ollie Brandon Alonzo Mason Driskill other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Driskill - Son 1041 Concord Court, Owings, MD 20736 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1
Department of I
Important: If it cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/20/2010 George Washigton Cemetery Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. ZAyRogus Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Unknown Physician/ Diabetes Mellitus disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 5 Days Pneumonia Sequentially list conditions, if any, leading to immediate cause, Liner Underlying Examine Due to (or as a consequence of): sician and burial-transit Unknown Cause (Disease or iinjury that initiated events Gangrene Due to (or as a consequence of) resulting in death) Last attending physician Unknown Physician/Medical The law requires that the death certificate be Alzheimers Box 68760 as the t IF FEMALE: Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) ed by the a 2 No 9 Unknown P.0. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Hypertension 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: Hospice 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) ည 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) scines CRI 2/15/2010 R134720

Registrar

State

Tiffany Gaines, 238 Merrimac Court, Prince Frederick, MD 20678

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2010 February 1536 Gloria Faye Divers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Cheverly 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months Hours Days Min. 1 □ M 2 🕅 F 14,1955 Washington, DC Yrs. April 577-78-4362 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Evarinat must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 □ No Director MD Prince George's Riverdale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20737 USA 6700 Greenvale Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2K No B1ack Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Housewife 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lonnie Bernard Bryant Sr Francine Gloria Faye Lewis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6700 Greenvale Parkway, Riverdale, MD 20737 Raphael Divers - Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Md Fort Lincoln Cemetery 2/8/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licens 716 Kennedy Street, NW, Washington, DC 23 . Part 1. Enter the disease, or carry lication, that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one race or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician was Massive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

P.O. Box 68760, Division of Vital Records,

prital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funetal director, page 2 should be detached for use as the burial-transit

Yes 2 No

5 ☐ Pending investigation

8 Could not be

determined

27. Manner of Death

Natural

2 Accident

4 Homicide

3 ☐ Suicide

Medical Certification: To 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINCE 31. Date filed (Month, Day, Year) FEB 1 7 2010 State 2010

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 npatient

28a. Date of Injury (Month, Day,

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16 / O Joyce Lee Delatte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SAlisbury HICOMICO if Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Months Hours Min. Maryland 0111911924 Director 86 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral 233 North Blvd. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White etc. 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Otis H. Messick Elva F. Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra T. Schaub/daughter 1309 Woodland Rd., Salisbury, MD 21801 f Health injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State wicomico Memorial
Park 1 X Burial 2 Cremation 3 Removal from State 2 15 10 Salisbury, MD 4 Donation 5 Other (Specify) Licensee ²² Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd, Salisbury, MD 21804 Ü 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEMOGYNAMIC COLLAPSE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HEMMORHAGE Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trans INFECTION that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year signed by the a Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate 2 X No 1 Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🔲 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F only one 29b. Signature and title of certifier Unu 0.0. 2/7/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 16

SALISBURY,

HEALTHWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month Vear **Physician** Birdie Mae Burnett February 10, 2010 Derry 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARRISON SENIOR LIVING SNOW HILL WORCESTER Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | V Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Voor Months 1 M 2 X F 407-16-8391 87 04 02 1922 Kentucky Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examinar must be notified at Maryland Worcester Ocean Pines 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 67 Bramblewood Drive 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes. Give Specify. þ white 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other them. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Abrin Burnett Mabel Ruth Duncan ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Therry daughter 67 Bramblewood Dr., Ocean Pines, MD 21811 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 2 12 10 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-transi Due to (or as a consequence of) Box 68760, physician Physician/Medical death certificate the as attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. | ed by the a detached f 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2. No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural spital or Attendi nours after death. neral Director: A / filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospital o within 24 hours aft To the Funeral Di 280

> State Registrar

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

1604 x

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:35 A[™] DONAWAY FEB 8 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 JUNE 30, 1930
 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 79 Director MARYLAND 220-26-1307 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND WORCESTER BERLIN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 'natural", or Items 23a 7932 PURNELL CROSSING ROAD 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1∐Yes 2∭ŽNo Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DONAWAY SR. CHARLIE ELIZABETH HOLLOWAY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7932 PURNELL CROSSING RD., BERLIN, MD 21811 MARGIE McBANE/FRIEND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal-from State DALE CEMETERY 2/13/10 WHALEYVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Enter the discase, or complications that as sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pumonory Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of a that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown , page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy
performed?

1 Yes 2 No certificate Division of Vital or Attending Physician: After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendii
within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 9733 Health Way Drive Berlin AGH Zeeshan. 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John O. Davis February 2010 12:06 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 € M 2 □ F Months Days Hours Min. 1/27/1969 173-26-9142 41 Pennsylvania Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 🏋 Yes 2 □ No Pennsylvania Schuylkill Frackville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17931 11 S. Wylam Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ 1 ☐ Yes 2 🎇 No Specify White Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United Cerebral Elementary/Seconday (0-12) College (1-4 or 5+) 12th Assembly Line Worker ·Palsv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Elmer C. Davis Arlene E. Rhodes Lege 1 and 2 sh.
Legartment of Health and
Important: If item 27 is many injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emerson C. Davis/ Brother 1159 Stiarna Ct., Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 Domation 5 Other (Specify) Kalas Crematory 2/9/10 Edgewater, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) weeks Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a g Unknown e Hospital or Attending Physician: The law requires that the a 24 hours after death.

24 hours after death.

25 Funeral Britis Petrificate has been signed by the Funeral filled in by the funeral director, page 2 should be detache leted filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Downs Syndrome 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No ည X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the dedical Examiner: On the b t of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ner: On the of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

State

Registrar

29b. Signature and

se Praction

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ertifying N

Steven C. Resnick, M.D.

of c

to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

600 Ridgely Ave., Annapolis, MD 21401

2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 21 per FH G901 3/2/10 dk

State of Maryland / Department of Health and Mental Hygiene 05936 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:17 A M Derek W.S. Edwards February 17,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Prince George's Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours Min 1 XM 2 □ F 80 United Kingdom March 6,1929 Director 577-70-2493 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinating that be natified at 1 √Yes 2 No Director DC None Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 4917 Foote St., United Kingdom Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Independent Bookseller 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marjorie Louisa Broyd Alexander Stewart Edwards ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fact Department of Health ar Important: If item 27 is any injury or other trau once. 1667 K St., NW 3720, Washington, DC 20006 Robert A. Gazzola/Attorney-in-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb.19, Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee M01315 Kevin G. DeVol per DVR 2222 Wisconsin AVe., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fatal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed ending physician and use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) ed by the a detached fr □Yes 2□No 9 Unknown cate has been signed | page 2 should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 X No 1 □ Yes 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year) 32. Regiørar's Signature

29b. Signature and title of certifier

30. Name and address of

Jennifer Whitfield-Bellows, MD., 3001 Hospital Dr., Cheverly, Md. 20785

source of cloath (Itam 23a) (Type, Print)

29c. License number

D67436

29d. Date signed (Month, Day, Year)

310

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State	State of Ma	aryland / [		ent of H cate of L			711	10	05937
			Registrar  1. Decedent's Name (First, Middle, Laster)	it)	<del>-</del>	00/11/10	ato or a	Journ	2. Date of Deat			3. Time of Death
	Physici		Kenneth Ja	ack Esl	nelman				Month Februar	y 12, 2	Year 2010	3:00 P ^M
1	/Medio		4a. Facility Name (If not institution, give		ic Lineari	4b. 0	City, Town, or	Location of Death		4c. County of Deat		1 3.00 1
	6.		Calvert Memorial I	lospital_				Frederic			Lvert	
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last bir	Yrs. If U		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign ntry)
	Director		204-14-2674 Usual Residence of Decedent	<b>**</b> ***	82	115.			01-18-1	928	Penn	sylvania
	nand ow at		10a. State 10b. County		10c. City, Tow	n or Location					1	Od. Inside City Limits
	Mary Fied s	tor	MD Calvert			S	o1omon	S				1 ☐ Yes 2 🎇 No
	or 28%	Director	10e. Street and Number				. Zip Code		1	0g. Citizen of	What Cour	ntry?
	th wij	al	13325 Dowell Road	l			20	688		Ţ	JSA	
	r dea tems er mi	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was D If Yes,	ecedent of Hi specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- po Rican, etc.)		ce - Americ	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 X Yes 2 ☐ N If Yes, Give Year or Dates: 1	016 66	1 □ Y€	es 21XINo	Specify:		Speci	fy:	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at		15. Decedent's Ed			. Decedent's	Usual Occup	ation		16b. Kind of E	whi	
5	in 72 n "na Aedic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)		(Give kind o	of work done of OT use retired	lurina most of worl	king		Jac 111000, 111	addity
212	y with giene rrtha	E O	Elementary/Secondary (0-12)	College (1-4or 5 1		sician	, Inst	rumental:	ist	U.S. A	Air Fo	orce
	al Hyger of the vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle, I	Maiden Surna	me)	
ylaı	ould b Ment arked atic e	P	Elmer Franklin	Eshelma	n ,			Emily	L.	I	linke	L
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (	Type. Print)	19b	. Mailing Add	Iress (Street a	and Number or Ru	ral Route Number	, City or Towr	n, State, Zip	Code)
	1 and Health Pm 27 ther t		Lynne C. Downs, of 20a. Method of Disposition	laughter		300 Ho		<u>Cliffs Ro</u>		tingtov 20c. Location		
٥	Pages Tent of Hant of Hant of Hant of Hant of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest of Interest		1 ☐ Burial 2 【XI Cremation 3 ☐		cemete	ry, crematory	or other plac	e)				·
Baltimore,	iit. Pagariment artment artant: It njury o		4 □ Donation 5 □ Other (Specification 21. Signature of Fineral Service Licer		Metro	-	n Crem ne and Addres	atory 2-1				
Ba	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee Rausch Funeral Home, P. 8325 Mt. Harmony Lane, Owings, MD 20736									
			23a. Part1. Enter the disease, or com	olications that caused	the death. Do						201	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	<	1.25-5-							Onset and Death
1	/Medical		disease or condition resulting in death)		Si S a consequence	of):						
П	Examiner		Sequentially list conditions	b. Preu	monia							
	pa ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	of):						
	recute and -trans	Examiner	that initiated events resulting in death) Last	C. Due to (or se	a consequence	of):						
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	alE			a consequence	01).						
587	ficate phys s the	edical		.d								
Box (	death certifica attending phate as the	M/c	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. D	ate of deliv	erv
ğ.	death e atter	icial	in the past 12 months?	1□Live birth 4□Pregnant at			oic pregnancy er <i>(specify)</i>				lonth	Day Year
P.0	res that the de signed by the a be detached	Physician/M	9 Unknown	9□Unknown								
	ss tha gned se det	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	n the underlyi	ing cause give	en in Part I.	23e. Did to	pacco use cor	ntribute to t	he cause of death?
Records,	w requir been si should t								1 🗆 Y	es 2 No	3 🗌 Proi	bably 4 Munknown
S	e law r has be je 2 sh	ple							24a. Was a	sv	. Were auto	opsy findings available impletion of cause of
<u>=</u>	The l	Completed							perform 1□ Yes	med? 2 XNo	death? 1 ☐ Yes	2 No
Vital	hysiclan: Th nis certificate I director, paç	Be	25. Was case referred to medical examiner?	Hospital:			Othe		th (Check only on	e)		
9	Phys this ral dir	-T	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injur		utpatient 3□ Time of	T DOA	4 LI Nursing H	ome 5 Reside		_	fy)
O	<b>5</b> 0 0 0	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Injury M	28c. Injur Worl	Yes 2 □ No	20d. Describe no	JW IIIJury Occo	ired	
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1	.)		30. Name and a ress of person who		eath (Item 23a)	(Type, Print)					1	
dR	WITI		Change Hopp, mo	32. Registra	pitel P	load	Prince	2 Frede	rick , A	un 3	067	8
	Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signature	6	l	-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death Month Physician -ICH 1 M9 ARO 1641 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolitan Assisted Living Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 577-38-7399 Months Days Hours Min. 12 M 2□ F Yrs. Director 78 11/17/1931 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, if e Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 959 Aqua Court 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korea δ 1 ☐ Yes 2√∑ No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ukn ပ Howard Elms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. Serena Boyd - Daughter 959 Aqua Court, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Baltimore Crematory 2/19/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Myelin . Kleleo 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been si ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate performe 2 No 1 ☐ Yes 1 🗌 Yes Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes မ 2 ER/Outpatient 3 DOA 1 Inpatient After this 6 Other (Specify) 5 Residence 28a. Date of Injury (Month, Day, Year) filled in by the funeral Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director: ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

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Name and address of person

31. Date filed (Month, Day,

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Year)

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2010

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HIGHWAY ANNAPOUS MPLYER

completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 9, 2010 9:00 A M Martha Esslinger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 199 Rollins Ave. #416 Rockville Montgomery **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months (Month, Day, Year) ug. 8.1918 Country) Russia Director 213-92-0928 91 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1x Yes 2 No Md . Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 199 ROLLINGS Ave. 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ğ 1 Never Married 2 Married 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Wildowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Translator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alexander Spiess Therese Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Haas (Friend) University Blvd.W.Aptll1 Kensington, Md. 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 【 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Chambers Crematory 4 Donation 5 Other (Specify) Feb. 16,2010 Riverdale, Md. 21. Signature of Funeral Service Licensee #670 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737 ram 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death .Physician/ WORSTIVE disease or condition newee Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other şignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ျ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

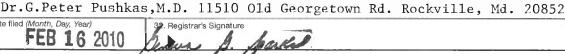
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Practicing 17: The boat of my investigation and one of the time date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar

FEB 16

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Steven Paul Fischer February 2010 РМ 1:03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 105 Simms Drive Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 09/25/1952 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. **1**√2 M 2 □ F 213-64-4486 57 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination as the retiffied at Director 1 □Yes 2 ¬No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 105 Simms Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 Yes 2 T If Yes, Give Year or Dates: 2 XNo Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify <u>چ</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Information Technologist State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Louis Fischer Rita Ann Viner ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Domino/Sister 904 DeCesaris Drive, Lothian, Maryland 20711 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Hillcrest Memorial Cem. 02/13/2010 | Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature un ral Service 22. Name and Address of FacilitGeorge P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Fart 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease of injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Neurofibromatosis23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform•rd? 1 □Yes 2 No certificate 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? v Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 □ Other (Specify) this i 24 hours after death.

e Funeral Director: After thi letely filled in by the funeral i •27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Faminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) tle of certifiéi D08194

12W

State Registrar 30. Name and au

Lichtenstein, 207 Ridgely Avenue, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature **FEB 12** 

dress of person who completed cause of death (Item 23a) (Type, Print)

parke

02/12/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Linda Mary Fitch 10:06 PM February 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yean. 26, 1 1 □ M 2 😾 F Months Days Hours New York 051-36-1509 Director 66 Jan. Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Village Montgomery 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be i Funeral 9509 Duffer Way 20886 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) Defense Contractor Meeting Planner marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F ೭ Donald McDermott Audrey Bell traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .5 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Bonnie L. Lane / Daughter 13224 Wye Oak Drive, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility
DeVol Funeral Home, 10
Gaithersburg, Signature of Funeral Service Licenses 10 East Deer Park Drive, org, MD 20877 TRACE mil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Physician/ Breast Cancer with Metastesis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last -tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 💢 No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ሺ Naturai work? 5 Pending n 24 hours after death.

Re Funeral Director: Af pleted filled in by the fu 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 only one) 29b. Signature and title of confiden 29d. Date signed (Month, Day, Year, D0062435 February 12, 2010

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Sayed Eisayyad, M.D., 10110 Molecular Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 05942

Physician/ I Examiner  1. Decedent's Name (First, Middle, Last)  Darren James Foltyn  4a. Facility Name (if not institution, give street and number) Rear of 2242 Old Washington Road  Tuneral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State or Foreign Washington number)   1. Decedent's Name (First, Middle, Last)  2. Date of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Death One of Dea			1- For State Certificate of Death	Reg. No
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29b. Signature and title of certifier  O.C.M.E.  February 20, 2010  30. Name and address of person who completed cause of death (Item 23a)	l or / after Dire	ŧ	3 Suicide 6 Could not be	or Town, State) Rear of 2242 01d
29b. Signature and title of certifier  O.C.M.E.  February 20, 2010  30. Name and address of person who completed cause of death (Item 23a)	hours neral		4 Homicide	
29b. Signature and title of certifier  O.C.M.E.  February 20, 2010  30. Name and address of person who completed cause of death (Item 23a)	n 24   n 24   ne Fu		(Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	a piace, and due to the cause(s) and mainter as stated.  h occurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier  O.C.M.E.  February 20, 2010  30. Name and address of person who completed cause of death (Item 23a)	中温专品	g	and manner stated.  20c License pure	
30. Name and address of person who completed cause of death (Item 23a)	E W S	≥		
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Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MiD 21201	of w	1	from stars y, "	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCIS Month JOHN GRECO 20% Medical 30M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2104 MEGHAN COURT ANNE ARUNDEL CROFTON 5. Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **OHIO** 1 M 2 □ F Months Days Hours Min. AUGUST 222° 1955 279-54-3677 Director 54 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL CROFTON 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2104 MEGHAN COURT 21114 UNITED STATES within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No 1973-Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 UVidowed 4 Divorced Specify: WHITE Completed 2007 Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) CAPTAIN UNITED STATES NAVY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည CARMEN GRECO ALICE DOUTHITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY A. GRECO/WIFE 2104 MEGHAN COURT, CROFTON, MARYLAND 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State CHESAPEARE CREMATION CENTER **FEBRUARY** 4 ☐ Donation 5 ☐ Other (Specify) 2010 STEVENSVILLE, MARYLAND Signature of Funeral Service Licens 22. Name and Address of Facility FELLOWS, ECREMATION AND FUNERAL CARE ROAD, ANNAPOLIS, MARYLAND HELFENBEIN AND NEWNAM ARE, P.A., 814 BESTGATE ND 21401 Will E M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ WISSENSON disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \mathbb{I} \) No Hospital: 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1. Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending Accident
Sulcide 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cartifier 29c. License number 21438 Ta WI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 📗 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARLENE AMOS GRANDERSON 02/70/3/2010 1240 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min (Month, Day, Year) 04/26/1938 Director 337-30-9661 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 14937 Ladymeade Circle 20906 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Black 3 Widowed 4 X Divorced Specify: other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) EOE Manager US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Amos Annabelle Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Granderson - daughter 14937 Ladymeade Circle, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from-State Sunset Cemetery 4 Donation 5 Other (Specify) 2/19/10 Northbrook, IL 21. Signature of Funeral Service Lic 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final obstructive Lang -hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by psis FROMECUL. has been sig ye 2 should b 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pertension 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate ha irector, page 2 autopsy performed' death? Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐No Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 29d. Date signed (Month, Day, Year) 3 2010 10 and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prive Phily Drive DENET TRAMA JUHJENGOLD 2083 2 31. Date file Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Month** 0430 Nellie Gear М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 8. Date of Birth 1 🗆 M 2 🖵 F Days Min Apr 30 Director 215-26-9964 ^{≞″}1928 81 Usual Residence of Decede show Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 XNo WV Mineral Wiley Ford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O. Box 68 26767 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harvey A. Sachs
19a. Informant's Name/Relationship (Type, Print) Mollie F. (Clites) Sachs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Gear 810 Shawnee Avenue MD 21502 son Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2/26/2010 Sunset Memorial Park Cumberland MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ di disease or condition resulting in death) Can Medical Due to (or as a consequence ) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in listed see or injury) Examine Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 🛂 Ño 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No ဂ္ 1 🗌 Yes Other: 1 Apatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after decay al Director. After work 1 🗌 Yes 2 🗌 No Accident Investigation n 24 hours after de ne Funeral Directo pleted filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completed t Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Vikramaditya Poonai M.D. e filed (Month, Day, Year) 32. Registr.

MAR 02

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32. Registrar's Signature

924 Seton Drive Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#5perfuneralhome2/18/10cchdof@Brtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Februar 9 13, 2010 Oscar Ghebelian 1:40p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Southern Maryland Hospital Clinton Prince George 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign <del>667</del>-18-6611 Months Days Hours July 10, 1922 Director New York Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Charles Indian Head Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3925 Stony Point Place 20640 U.S.A. items death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 1 2 Yes 2 No
If Yes, Give
Year or Dates. 9 Black, White, etc. 72 hours after Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1943 and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Specify: White 1975 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Air Force Band U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Krikor Ghebelian Takook Anapanossian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Caroline S. Ghebelian 3925 Stony Point Place, Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 2010 1 Burial 2 X Cremation 3 Removal from State Metropolitan Funeral Service 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Se 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the di shock, or heart in bease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flure. List only one cause on each line. Interval Between A cute Respiratory Failure with Rypoxemi Immediate Cause (Final Ph_sician/ Onset and Death disease or condition Medical resulting in death) to for as a consequence of the bation for respiratory failure Examiner my ductioned to agree for Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine edared DNA signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed Pempheral Vereulan Disease and Canobid Slanes 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown Non Hodgicin Lymphoma 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate Yes 2 No 1 Tes 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deal 1 Natural 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 5 Pending injury n 24 hours and he Funeral Director: Af Accident
Suicide Investigation 1 Tyes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number **Asyland** 29b. Signature and title of certifier Kuchhofla Sublac Rao, H.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenbelf, Mi KUCHIBHOTLA

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

18 2010

SUBBA

Registrar's Signatu

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Joseph Aubrey Gragan, Jr. :53 2010 CAM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center Charle La atta If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 <del>□</del> M 2 □ F 219-84-9458 48 July 11,1961 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Charles Bel Alton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9755 Bel Alton Newtown Road 20611 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No White 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Treasurer Glass Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Aubrey Gragan, Sr. Helen M. Gragan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Gragan/Son P.O. Box 182, Bel Alton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State St. Ignatius Cemetery 2/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Port Tobacco, Maryland M0094521. Signature of Funeral Service Licenses AREHART ECHOES FUNERAL HOME, P.A. alur St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) athero scleronc Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last huner tension to (or a consequence of): Due to (or as a consequence of)

**Physician** /Medical Examiner

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, In a In once.

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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**Funeral** 

**Director** 

"natural", or items 23a or 28a-f shov

MR-46393

Baltimore, Maryland 21215-0036

Examiner ģ Be Completed

the attending physician and thed for use as the burial-tran Physician/Medical signed by the a page 2 should has

Certification: To

Medical

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page BBU

	d.		publice of).						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6	al death 3 🗆 Ectop	c pregnancy (specify)			23d. Date of d Month	elivery Day	Year
Part II. Other significant condition	ens cont	tributing to death but not res	ulting in the underlyin	g cause given in	Part I.	23e. Did tobacc	o use contribute		
						24a. Was an autopsy performed?	prior to		gs available of cause of
25. Was case referred to medical examiner?				26.	Place of Death	(Check only one)			
1 Yes 212 No	Ho	ospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3□	DOA Other: 4	☐ Nursing Hon	ne 5 🗆 Residence	6 ☐ Other (Sp	ecify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes	2	8d. Describe how in			
3 Suicide 6 Could n 4 Homicide determi		28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact	ory, office	2	8f. Location (Street City or Town, Sta	and Number or Fite)	Rural Route N	umber,
29a. Certifier 1 Certifying (Check only 2 Medical E	g Physi Examin	cian: To the best of my knoer: On the basis of examina and manner stated.	owledge, death occurr tion and/or investigat	ed at the time, d on, in my opinio	ate and place, a	nd due to the cause d at the time, date a	(s) and manner nd place, and du	as stated.	e(s)

29c. License number

LAPLATA.

29d. Date signed (Month, Day, Year)

02-13-2010

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

5 GARRETT AVE. 32. Registrar's Signature

W1.6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 - 05949 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 1125TM Physician/ Gray Craven Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Wicomico Salis buri at the Coastal Mospice 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 6. Sex Social Security Number Days Funeral Hours (Month, Day, Months 1 🗆 M 2 🛛 F Arkansas Director 215-36-4099 Usual Residence of Decedent 10d, Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Salisbury Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21801 1012 Riverside Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 11. Marital Status 1 Never Married 2 Married ģ White 1 ☐ Yes 2X No Specify: Maryland 21215-0036 Completed Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Secretary 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) မ Liddel1 Eunice McNeil Craven 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1012 Riverside Drive, Salisbury, Maryland 21801 Judy Power – Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Salisbury, Maryland 2-20-2010 Wicomico Memorial Pk. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bounds Funeral Home Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dast only one cause on each line. Interval Between Onset and Death ALZHZIMRIZ DISRASA Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Day Month in the past 12 months? 4 Pregnant at time of death
9 Unknown signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? peen 24a. Was an autopsy cate has I performed No 27 No 1 🗌 Yes certificate 26. Place of Death (Check only one) within 24 hours after death,

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 4 Nursing Home 5 Residence 1 🗌 Yes ပ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 5 Pending 🛚 Natural 1 🗌 Yes 2 🗌 No Division 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 L only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ပ္ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

DHMH 17 Rev 7/2009

State

Registrar

6 Huyan 31. Date filed (Month, Day, Year)

FEB 16 2010

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3. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Februar Physician/ 2:06 AMBERRY GOODING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 🗆 M 2 🔀 F Months Days Hours Country) **Director** 212-24-4092 80 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho Funeral Director MD Frederick Frederick 1 🗌 Yes 2 ី No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1338 Hillcrest Drive 21703 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Billing Veterinary Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Granville Berry Catherine Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is any injury or when Linda Grimes Daughter 1338 Hillcrest Dr. Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Smithsburg Crematory 2-19-2010 | Smithsburg, Maryland 4 Donation 5 Other (Specify 22. Name and Address of Facility 21. Signature Fun al Sen Keeney & Basford P.A. F.H. MO1176 106 East Church Street Frederick, MD 21701 ar 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest fock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Ph sician/ Sepsis disease or condition resulting in death) Medical 40 4 THS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine MATH. Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year 1 ☐ Tes 2. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signat tle of certifier Date signed (Month, Day, Year) MDD62223 ess of person who completed cause of death (Item 23a) (Type, Print) #225 Praveen K Bolarum

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

WAR 02

bhnson DR.

196 Thomas

32. Registrar's Signature

21700

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Certification: To within 24 hours after deatl To the Funeral Director; crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRN 100 Uskesh Vathur 31. Date filed (Month, Day, Year, 32. Registraris Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05952 State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2/12/2010 ay 6:2888P M Elizabeth Eleanor Hall Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester 10434 Brighton Rd Cean City 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🏻 F Months Days Hours Min 1 1 1 3 / 1 9 2 9 Wash DC 81 **Director** 577-38-8297 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland at Hygiene. 1 other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 No Prince George Laure1 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20708 9264 Cherry Lane 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the Bank of America Bank Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental cant: If item 27 is marked of ည Edna M. Hill Dennis Joseph Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10434 Brighton Rd, Ocean City, MD 21842 Tish Muela (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/15/2010 Cape Henlopen Crem. Frankford, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses  $^{22.\,\text{Name}}$  and Address of Facility. The Burbage Funeral Home  $108\,$  William St.Berlin MD 2181122. Name and Address of Facility 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ardio Myoperthe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) Pregnant at time of death signed by the a ld be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ The law requires 3 Probably 4 Unknown Division of Vital Records, 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 🔫 No ည 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 🔼 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be ☐ Suiciae ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the less of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one . Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 Salist Dasta Date filed (Month, Day, Year) State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05953 State of Maryland / Department of Health and Mental Hygiene 2 () 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Feb 8. 201°0 17:29 P M Physician/ Hoffman Mildred Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (if not institution, give street and number) **Examiner** Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year 1927 Hours Alabama 0ct_ 82 577 32 9956 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Waldorf, Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20602 Funeral United States 1101 Hamlin Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces Yes 2 XXVo 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 VNo Specify. Specify White If Yes. Give 3√X Widowed 4 □ Divorced Completed Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Union #26 Secretary 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Magruder Lillian Alvin Viddetto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark Hoffman (Son) 1101 Hamlin Road, Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Neurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 2/16/2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Signature of Funeral Service Licenses Alexandria Ferry Road, Clinton, MD 20735 M0025 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dué to (or as a consequente Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month Year Day in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a d be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Impleted cause of death (Item 23a) (Type, Print) Name and address of person who

Registrar

DHMH 17 Rev 7/2009

State

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10-01546 William Hidey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		l- For State Registrar	С	ertificate of	Death			g. No.			
Physician/ 1. Decade   Name (First, Middle, Last)   Stevens   Hidey   2. Date   Mon								Day Year	3. Time of Death 1134 hrs		
Hical Exami	ner				b. City, Town, or L	ocation of Death	February 2	20, 2010 4c. County o			
		4a. Facility Name (if not institution, giv Western Maryland Health		-	Cumberland	ocation of Death	,	Allegany	Douti		
Funeral		5. Social Security Number 6. Se	<u> </u>	s. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Bir	th(MM/DD/YYYY)	Birthplace (State or		
Director		219 49 0770 X	Jun 1	5, 1947	Foreign Country MD						
	ŀ	Usual Residence of Decedent									
any	ı	10a. StayID 10b. Countallegany 10c. City, Town or Cumberland									
		7 4110 8	,,	Oun	iberiaria				1 Yes 2 No		
Aaryland 28a-f show 1 at once.	윐	10e. Street and Number Mason F	Pood NE		10f. Zip Code	24500	10g. Citizen of What Country?				
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	Director	11001 Mason F	toad INE			21502			USA		
with 18 23		11. Marital Status X	12. Was Decedent Ever in	anic Origin? ( Sp		- 14 Race White	- American Indian, Black,				
death r iter	Funeral	1 Never Married 2 Married	Armed Forces 🗶		es, specify Cuban,	Mexican, Puerto	Rican, etc.)		white		
after al", c	by		If Yes, Give Year or Dates:	1		specify:		Specify:			
hours	9	15. Decedent's Education (Specify or	on (Give kind of w DO NOT use retir		16b. Kind of Bus						
2 3	Completed	Elementary/Secondary 20-12)	College (1-4 or 5+)	lawye	r			law of	tice		
5-00 lled with Hygiene I other I	ĕ	17. Father's With Emman	att Hidey		11	8.Mother A Name	(First Middle,	Burns)"	lidov		
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2121 ould be f I Mental s marked	ျ	19a. In Sines a Werner Telegraphip (T	ype, Print) wife	19b. Mailing	8013Mast	m Road	NEE Route Chur	mbertam	State, 700000 21502		
and 2 sho fealth and feal 27 is											
		20a. Method of Disposition  1 Burial 2 Cremation 3		b. Place of Dispos crematory or oth Sunset Men		etery,	Date 2/25/201		City or Town, State berland MD		
MOFE Pages 1 nent of H ant: If i		4 Donation 5 Other Specify				W 5		Juni	Donaria W.D		
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other t	- 1	21. Signature of Funeral Service Licer	see	22. N	ame an 108 Vir	r la u t ginia Avenu	nue: Cumberland, MD 21502				
	_	23a. Part I. Enter the disease, or comp	limitions that assessed the do	eath. Do not optor th							
Physician /Medical	- 1	failure. List only one cause on ea	ach line.					cot, shoot, or not	Between Onset and Death		
Examiner		Immediate Cause (Final disease a. or condition resulting in death)	Atherosclerot  Due to (or as a consequence		ovascula:	r diseas	е				
		Sequentially list conditions, b.									
	횰	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	ce of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):							
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760, Icate b g physic	₩ W	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p	regnancy				23d. Date of			
Sox 68 leath certiff e attending for use as 1	sician	past 12 months?	1 Live birth 4 Pregnant at time o	f dooth	al death 3 ner (Specify)	Ectopic pregna	ncy	Month	Day Year		
Box 68 death certif he attending	ysic	1 Yes 2 No 9 Unknown		3 Oti	ier (opecny)						
O. B at the d lby the	Phy	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause gi	ven in Part I	23e. Did to		bute to the cause of death?		
, P.O. res that the signed by be detach	d by						1Ye	s 2 No 3	Probably 4 🗸 Unknown		
ords w requi	Completed						24a. Was		Vere autopsy findings available rior to completion of cause of		
SCO te law te has ge 2 s	Εď							rm <u>ed</u> ? d	eath?  Yes 2 No		
tal Recian: The l		25. Was case referred to medical			26 Place	of Death (Check of					
Vita ysicia his ce direct	o Be	examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatient 2	✓ ER/Outpatient	3 DOA	Other: Nursin	g Home 5	Residence 6	Other:		
Division of Vital Records, rat or attending Physician: The law requirers after death.  at Director: After this certificate has been siled in by the funeral director, page 2 should be	n: To	27. Manner of Death	28a Date of Injury (Month, Day, Year)	28b. Time of I	njury 28c. Injury	y at Work?	28d. Describe	how injury occurre	ed		
ion tendii eath. lor: /	ațio	1 X Natural 5 Pending 2 Accident Investigat			1 Y	es 2 No					
Divis pital or At purs after d eral Direct	Certification:	3 Suicide 6 Could not	be 28e. Place of Injury - A	At home, farm, stree	et, factory, office bu	ailding, etc.	28f. Location ( or Town, \$		er or Rural Route Number, City		
Spital nours and filled	Se	4 Homicide determine	(4,444)								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as			ian: To the best of my know r:On the basis of examination								
To the within 7 To the complet	Medical	29b Signature and title of contier	and manner stated.		29c. License				ed (Month, Day, Year)		
			11 //		O.C.N			February 2	,		
_		30. Name and address of p son who	completed cause of death (	Item 23a)							
Ų	2	/	Chief Medical Exami		n Street, Balti	imore, MD 21	201		,		
s	tate	31. Date filed (Month Pay, Pean 2	2010 32. Redistrar's Sig	nature	0.00						
Regis	trar	,,,,,,,	Lord Consum	1. 14	and the second						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** rebruan 2010 MILTON FRED HEIN, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Plata narle Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-13-1931 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days IOWA Months 1**∑**M 2□F 78 578-46-4672 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show If is marked other than "natural", or items 23a or 28a-f show traumatic event, the backed Experiment must be notified as 1 □Yes 2 TXNo Director MD. CHARLES NEWBURG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10670 LLOYD POINT ROAD 20664 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 Xes 2 No USMC If Yes, Give Year or Dates: KOREA 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 TNo Specify. SpecifyWHITE \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MIL-MAR, INC. HOME BUILDER 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental F VIRGINIA MAY DONNER MILTON FRED HEIN, SR. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health 10670 LLOYD POINT RD. NEWBURG, MD. 20664 MARGARET M. HEIN-SPOUSE item 27 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GHOST CEMETERY 3-2-2010 ISSUE, MD. 4 Donation 5 Dother (Specify) HOLY 22. Name and Address of Facility 21. Signature of Funeral Service License MO0479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 91 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami physician and is the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by (gretion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should I Corona 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 15 cocku 2 DINo 1 ☐ Yes 2 ☐ No Tuph 1 ☐ Yes 25. Was case referred to medical examiner? Be ( funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2-24-10 ed cause of death (Item 23a) (Type, Print 30. Name and address of person who comple 30x 2665 La Plata, MD 20646 Jenkins Lal Transe arn 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 05956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [□]16, February Robert Meredith 2010 2:30 P M Haynes Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth March 10 Funeral If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign ^{Year)}19<u>35</u> 1 **X** M 2 □ F Days Hours 214-34-0058 Mary land **Director** 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have acted. 10a, State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No PA Franklin Fayetteville 10e. Street and Number 10g. Citizen of What Country? 6310 Oak Leaf Lane 17222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Comptroller Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ H. Alan Haynes Louise Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Haynes / Wife 6310 Oak Leaf Lane Fayetteville, PA 17222 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 02/18/2010 Frederick, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licer 7606 Old National Pike Boonsboro, MD 23a. Part 1. Inter the disease, or complicated is to shock, or heart failure. List only one large on t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ UNUNLA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alnenes Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 is autopsy performed death? Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 🗌 Yes 1 Department 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ature and title of certifie Mrce 11

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Q

TIL

10-01071 Julie Higgins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ulle Higgins		1- For State Registrar	tate of Maryla		artment d rtificate d			vientai F		eg. No. 201	0 0595
Physici Medical Exami		1. Decedent's Name (First, Midd Julie Marie H							2. Date of Dea Month February	Day Year	3. Time of Death 0850 hrs
		4a. Facility Name (if not instituti 11411 Boyd Road			own, or Loc Spring	ation of Deat		4c. County of Dea Washington	eth		
Funeral Director		5. Social Security Number 217–76–9409	6. Sex	7. Age (In yrs. 50		Months		f Under 24Hr Hours Mi	1	rth(MM/DD/YYYY) 9. E	
any		Usual Residence of Decedent 10a, State 10b. County		10c. City	, Town or Loca	ation					10d. Inside City Limits
Maryland 28a-f show d at once.	ō		shington		Clea	r Spr					1 Yes 2 X No
i with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Number  11411 Boyd Ro	ad			10f. Zip				10g. Citizen of What Co USA	untry?
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 X	12. Was Dec Armed Fo	2 X No	1f	/as Deceder Yes, specify	nt of Hispan Cuban, Me	exican, Puert	Specify Yes or No o Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
urs after tural",	à	3 Widowed 4 Di	vorced If Yes, Give Yea or Dates: ecify only highest grad		16a. Decede		Occupation	(Give kind of		Specify:	
5-0036 filed within 72 hour Hygiene. d other than "natu	Completed	Elementary/Secondary (0-12)	0	-4 or 5+)		most of work emaker		NOT use re			wn home
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle William Marma							e (First, Middle, unknown	Maiden Surname)	
0		19a Informant's Name/Relation Gary Higgins,								mber, City or Town, Sta	
e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition		20b.	Place of Dispo	osition (Nam			Date Date	ng, Marylan 20c. Location - City of	
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and M Important: If item 27 is in injury or other traumatic		Burial 2 X Cremation  Onation 5 Other 5	_	UIII Glate	crematory or c gersto	wn Cr			18/10		m, Maryland
Baltimore, MD permit. Pages I and 2 shu Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Funeral Service	e Licensee		22. 4	Name and	Address of I Wile	Facility MI	NNICH FU	UNERAL HOME erstown, Md	2 1. 21740
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	e on each line.		. Do not enter	the mode o					Approximate Interval Between Onset and
taminer		Immediate Cause (Final disease or condition resulting in death)		ve Cardiova consequence o		ease					Death
	Je.	Sequentially list conditions, if any, leading to immediate		consequence of	of):						
uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of	of):						
), be exect iician an urial - tr	Medical	UNPENDED	AMENDED								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9  ✓ Ur	the 1 Live b	ant at time of de	2 F	etal death Other (Spec		Ectopic pregn	ancy	23d. Date of delive Month	ory Day <b>Y</b> ear
, P.O. B ires that the d signed by the	ā	Part II. Other significant condi	tions contributing to	death but not r	esulting in the	underlying	cause giver	n in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
cords law requi	Completed									psy prior to prmed? death?	
tal Rectian: The certificate ector, page	Be Co	25. Was case referred to medic examiner?				2		Death (Check		2 No 1	Yes 2 No
n of Vital   ding Physician: h. After this certif	은	1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 1 28a. Date (Month	npatient 2 of Injury	ER/Outpatier		OA Oth 8c. Injury at			Residence 6  Oth	er: Scene
ion of trending Pheath.	ation		(Month ding estigation	, Day,Year)				2 No		, , , , , , , , , , , , , , , , , , , ,	
Division  To the Hospital or Attent within 24 hours after death  To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 Cou		e of Injury - At h	ome, farm, str	eet, factory,	office build	ing, etc.	28f. Location ( or Town, S		Rural Route Number, City
the Ho thin 24 l the Fu	Medical		aminer:On the basis	of examination a						se(s) and manner as standard and place, and due to	
To viii	Me	29b. Signature and title of certif	and manner s	tateo.		290	License nu			29d. Date signed (M	
1		30. Name and address of perso	n who completed cause	se of death (Item	M/	7	O.C.M.E	=. 		February 15, 20	)10
		Russell Alexander Mi	O. Assistant M	ledical Exar	niner 11	1 Penn S	treet, Ba	altimore, M	ID 21201		
S	tate	31. Date filed (Mont)	7 2010 32. Re	istrar's Signat	ure	ake	1			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G901 3/17/2010 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2010 /Medical City, Town, or Location of Death 4c. County of Death not institution, give street and number) Examiner enter //ana If Under 24 Hrs. 8. Date of Birth (Month, Day, August 9 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Hours 1 □ M 2 🛛 F 579-22-3085 87 Berwyn Heights MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ural", or Items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 900 Van Buren Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Frances Stubblefield Oliver Charles Prosser ٥ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 254 Elkton South, Laurel, MD 20724 Heather Y. Hansen / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3/15/2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 2/19/2010 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Jaye TRAY Rogers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Ulaknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate l 2 4 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nureing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA ၉ 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 24 within 24 and manner stated. 29d. Datersigned (Month, Day, Year) 29b. Signature and title of certifier 29c, License number Name and address of person who completed cause

State Registrar 31. Date filed (Month, Day, Year)

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 10, 2010 Elizabeth Hershman 6:52 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 102 Pineherst Road Ocean Pines Worcester 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 □ M 2**X** F Days Hours 05/10/1918 160-10-3226 Director Pennsyl<u>vania</u> 91 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Ocean Pines Maryland Worcester 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 102 Pineherst Road USA should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sales retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Saiken Bessie Snyder permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print)
Barbara Southwell/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 102 Pineherst Rd., Ocean Pines, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt. Jacob Cemetery 2 | 14 | 10 Glenolden, PA 4 Donation 5 Other (Specify) 21. Signature of Furieral Service Lice 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Emboli Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-translt To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Stanosis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Year Pregnant at time of death Day by the a P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes Division of Vital 25. Was case ferred to medical examiner. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dii 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) medical Doctor 112 00069257

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 16

back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 47 314

. Registrar's Signat

			For State Registrar	State o	f Maryland		artment rtificate					giene Reg. No-	010	05960
Æ	Physici	on	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medi		Walter Franklin	Jones, Sr.							February	6, 201	0	10:14 p ^M
	Examir	ner	4a. Facility Name (If not institution		nber)		_ ,,		Location of				County of Death	1
			Calvert Memoria 5. Social Security Number	l Hospital	7. Age (In yrs. la	et hirthday)	Princ If Under		ederick If Under		8. Date of Birt		alvert	place (State or Foreign
L	Funeral Director		217-01-7452 Usual Residence of Decedent	1 M 2 □ F	97	Yrs.	Months	Days	Hours	Min.	(Month, Day Septembe	v, Year)	Cou	intry)
	yland now at		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	a-f sh	ctor	MD Calve	rt	Hur	ntingtov	vn							1 ☐ Yes 2 🗷 No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Cou	intry?
	ath w	rai	2079 Plum Point	Road			206					USA		
	er de Items	Funeral	11. Marital Status	Armed Fo		13.	Was Deced If Yes, spec	lent of Hi cify Cuba	ispanic Ori an, Mexicar	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)	. 14	<ol> <li>Race - Ameri Black, White</li> </ol>	
36	rs aft I", or xami	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or Da	e		1□Yes 2	2 <b>⊠</b> ,No	Specify:				Specify:	Dia als
21215-0036	2 hou	ed	15. Decedent	's Education		16a. Dece	dent's Usua	d Occupa	ation			16b. Kind	d of Business/Ir	Black
215	hin 72 nn "nn Medi	ple	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired	during mos I)	t of workii	ng			
7	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medisal Examiner must be notified at	Completed	6	Jamaga (.				Fore	eman			Unior	n Constru	uction
nd	be file	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden S	Surname)	
yla	Ment Ment arked atic	၉	William Jones						Lena	Victo	ria Morse	ell		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh				-						Town, State, Zi	ip Code)
e,	1 and Health	12	Joyce L 20a. Method of Disposition	. Rice - dau		P.O			Huntin		n, MD 20		ation - City or T	Town State
Jor	Pages nent of h ant: If ite ury or of		1 Burial 2 ☐ Cremation		State ce.	metery, crei	natorý or ot	ther plac	i					
Baltimore,	artme ortani injury		4 ☐ Donation 5 ☐ Other (S _k 21. Signature of Funeral Service I		You		nurch C 2. Name and						ngtown, N	MD
Ba	permi Depa Impo any is		> Blades G		1					Sew	ell Funera		•	70
6			23a, Part1, Enter the disease, or	complications that c	aused the death.								, MD 206	Approximate
e e	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition		RON	may	AR	TER	Ry	7	SEASO			Interval Between Onset and Death
2	/Medical Examiner		resulting in death)	Due to (	or as a conseque	ence of):								
k	1.35	7	Sequentially list conditions,	b. Due to l	or as a conseque	ancia ofic								
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	200	on als in conductive	or again conj								
,	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	c Due to (	or as a conseque	ence of):								
760,	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical		d										
9	rtifical ng ph) as th			1								1		
Вох	leath certific attending p I for use as i	an/N	IF FEMALE: 23b. Was decedent pregnant		come pf pregnan		Ectopic pre	eanancv	,			23	3d. Date of deliv	•
E	e dea he at ied fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of dea		Other (spe						Month	Day Year
P.O.	uires that the de signed by the a Id be detached f	Phy	9 ☐ Unknown  Part II. Other significant conditio	ne contributing to de	oth but not recult	ling in the u	adorluina oa	una aire	en in Dort I		220 Did to	bassa us	a contributa to	the cause of death?
Records,	signe signe	þ	Cerebenia					tuse give	siriir aiti.		1 □ Y		_	bably 4 Unknown
Ö	w require been si should b	etec		<del></del>							-			
Rec	has ge 2 s	Completed by									24a. Was autop	an sy rmed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
g	n: Ti ficate or, pa	ပ္ပ	25. Was case referred to medical								1□ Yes	2 400	1 ☐ Yes	2 <del>1 No</del>
Vita	Physician: The le r this certificate had ral director, page 2	o Be	examiner?	Hospital:	npatient 2	P/Outpatien	t 3□ DO	Δ Othe	or:		(Check only of		——————————————————————————————————————	
ō	g Phy er this eral d		27. Manner of Death	28a. Date of	of Injury 2	28b. Time of		Bc. Injury Work			ne 5 🗀 Resid 28d. Describe h		Other (Speciocurred	ity)
0	nding ath. r: Aft	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investig		h, Day Year)	Injury	М		c? Yes 2∐I	No				
Division or	If or Attend after death.   Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	Zoe. Place	of injury - At hom	ne, farm, str	eet, factory,	, office		2	28f. Location (S City or Tow	Street and	Number or Rui	ral Route Number,
٥	ital o rs aft ral Di led in	Cer		1										
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, f.	edical	29a. Certifier 1 ☐ CertifyIng (Check only one) 2 ☐ Medical I	g Physician: To the Examiner: On the ba	asis of examination	ledge, deatl on and/or in	n occurred a vestigation,	at the tin in my o	ne, date an pinion, dea	nd place, a ath occurr	and due to the e	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	o the vithin ( o the omple	Med	29b. Signature and title of certifier	and manr	ier stateu.		29c.	. License	e number			29d. Date	signed (Month	, Day, Year)
<b>b</b>	⊢≯⊢ŏ		· 1/~~	NATA	w.	N	1	>_	-25	4=	35	2	181	10
	-(1.		30. Name and address of person v	who completed cause	e of death (Item 2	23a) (Type	Print)						(0)	-
dr	W 5		Mukesh N	lathur	4	-, (. / Þ0,			Pr	inc	e Fre	deri	ick, M	0 20678
	Sta		31. Date filed (Month, Day, Year)		egistraris Signatu		A. a.	- Tri 144			•		/	-
	Registr	ar	FER	1 7 2010	Mr. and		As in	P. S						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ NES 023 DM -ERU-1 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS 701 Glenwood St. Apt 708 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. May 11 1932 Maryland 214-30-5656 77 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 ☐ No Maryland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 21401 701 Glenwood St. Apt 708 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Person Liquor Store Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence Jones William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kirby(Son) 3860 Redbud Ct. Smyrna, Ga. 30082 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2-16-10 4 Donation 5 Other (Specify) Maryland Veteran Crownsville, Md. 21. Signature of Funeral Service Licensee Windows a Reducer Section Facility Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 MO048 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): g physician a is the burial-t Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð PANCREATIRS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' certificate 1 Yes 2 No the Hospital or Attending Physician: Thin 24 hours after death.

the Funeral Director: After this certific mpleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DEFENSE HIGHWAY ANN ARKIMDLING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

MICHAR 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

CalENTA in

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ John Benedict Joy, Jr. February 2010 Medical 4b. City, Town, or Location of Death Annapolis Facility Name (if not institution, give street and number) Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₹ M 2 □ F Months 212-28-2243 77 Director 8, 1932 Aua. Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1202 McKinley Street 21403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No 72 hours after 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner **HVAC** 12 is marked other Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental 2 John Benedict Joy Roberta Estelle Atwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Wilma Joy/wife 1202 McKinley Street Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Garden's 2/20/2010 injury Annapolis, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Servi 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Acute Myocardial Infarction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) signed by the a d be detached for 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NIDDM 2℃No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No High Blood Pressure 24a. Was an autopsy performed? Yes 2XXV page 2 this certificate COPD 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Yes 2**X**XNo မ 1 Inpatient 2XXER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury X Natural 5 Pending after death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9:50

9. Birthplace (State or Foreign

10d. Inside City Limits

21403

Approximate Interval Between Onset and Death

sudden

years

Day

City or Town, State)

29d. Date signed (Month, Day, Year,

February 8, 2010

Year

Yes 2 No

Marvland

U.S.A.

White

 $A^{M}$ 

CH12

State Registrar

24 hours a Funeral L

To the Hosp within 24 ho To the Fune completed t

Medical

29a. Certifier

(Check only one) 29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.D. Krimins, MD 104 Ridgely Avenue

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 12 2010

1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Our tifying Nurse fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D23142

Annapolis, Maryland

29c. License numl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg, No. 2010

		-	For State Registrar	State of Ma	arylanu /		tificate of E			Reg. No. 2	010	05963
П	Physicia	n/	1. Decedent's Name (First, Middle, La MARGARET IRENE						2. Date of De Month 02/04/		Year	3. Time of Death
,	Medic Examin		4a. Facility Name (if not institution, giv				4b. City, Town, or	Location of Death	1 02/04/	4c. Co	ounty of Death	1.0233
~			Shady Grove Adver	ntist Hospi	tal		Rockvil	le		Mon-	tgomer	У
	Funeral Director		161-32-0514	1 M 2 X E	(In yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 04/11/	th 1939	9. Birth PA	hplace (State or Foreign Intry)
	and show	ō	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
	Maryla 28a-f	Director	MD Montgome	ery	Rockvi	ille						1 ☐ Yes 2 🔀 No
	h the	a D	10e. Street and Number				10f. Zip Code			-	n of What Cou	untry?
	ath wit	Funeral	1105 Allison Dri	VE 12. Was Decedent Ev	vor in LLS	13 \	20851	spanic Origin? (Sr	pecify Ves or No-	USA	Race - Amer	ican Indian
9	er dek or ite miner	by Fi	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2X Married</li></ul>	Armed Forceş? 1 ☐ Yes 2 🕅 N			/as Decedent of Hi Yes, specify Cuba		o Rican, etc.)	14.	Black, White	
003	urs aff :ural", al Exa	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.			☐ Yes 2X No			Spe	ecify: W	hite
15-	72 ho n "nat fedic	Completed	15. Decedent's (Specify only highest g	grade completed)		(Give k	ent's Usual Occupi ind of work done o ONOT use retired)		king	16b. Kind	of Business I	ndustry
212	Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description									Ponti	ac	
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yla	uld be I Meni narke natic	잍	James Shumar						t Irene			
Maryland 21215-0036	2 sho Ith and 27 is r traun		19a. Informant's Name/Relationship	, , ,	- 1		g Address (Street a			-		
re,	1 and of Hea item		Dawn Pritchard - 20a. Method of Disposition		20b. Place	e of Dispos	sition (Name of atory or other place		Date Germa		tion - City or	
imo	Page ment c ant: If ury or		1 <mark>X</mark> Burial 2 ☐ Cremation 3 d 4 ☐ Dengtion 5 ☐ Other (Spec	☐ Removal from State	Alji/	Soul	s Cemete:	ry 02/	15/10	Germ	antown	, MD
Baltimore,	permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	Sugar	b	. /I	Name and Addres					
		П	23a. Part 1. Enter the di ase, or cor shock, or heart fail re. List only	n cations that caused ne cause on each line.	the death.	not enter	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician/	П	Immediate Cause (Fin a disease or condition			k due	to UTI					Onset and Death
-	Medical Examiner	П	resulting in death)	Due to (or as a Acute	-		u <b>r</b> o					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (bras a			are					
	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events	U			failure					
_	icate be executed I physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a	consequenc	ce of):						
2092	ificate bing physical as the b	Aedical		<b>d</b>				-				
89	death certific he attending ped for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnanc	у		230	d. Date of deli	,
Вох	e e e	Physician/N	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Year
P.O.	es that the dee signed by the a l be detached f	by Ph	Part II. Other significant conditions	contributing to death bu	ut not resultir	ng in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ds,	requires been sign should be	ted k							1 🗆	Yes 2 🗆	No 3□Pr	obably 4 X Unknown
COL	The law requires that the arte has been signed by the page 2 should be detach	Completed							24a. Was auto			opsy findings available completion of cause of
- R	ician: The law certificate has ector, page 2 s		25. Was case referred to medical				26 0	ace of Death (Che	1 \( \text{Yes}	2 No		2 🗆 No
Vita	Physician: this certific ral director,	To Be	examiner? 1 🗌 Yes 2 🔀 No	Hospital:	ent 2 🗆 ER/	/Outpatien	Othe	er:	Home 5 ☐ Resi	dence 6 🗆	Other (Speci	ífv)
Division of Vital Records,	Attending Physr death. ector: After thi by the funeral		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigati	28a. Date of injur (Month, Day,	y 28	b. Time of injury	28c. Injury work	/ at	28d. Describe			
ivisio	il or Atte safter des Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			, farm, stre	et, factory, office		28f. Location (a City or Tox		umber or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 Medical Exal	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	camination an	nd/or investi	igation, in my opinio	n, death occurred	at the time, date	and place, an	nd due to the c	ause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier  JAWAD	_		· <b>\</b>	29c. License			29d. Date s	igned (Month	
	•		30. Name and address of person who							02/	04/10	
			Jawad Arshad 9	901 Medical	l Cent	er Dr	rive, Roc	kville,	MD 2085	0		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) FEB 16 20	10 Lengistra	r's Signature	par	es.					

of Maryland / Department of Health and N tal Hygiene 🤈 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month Fe, bruar 2010 907 AM Ethel Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Doctor's Community Hospital Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, South Carolina Director 578-42-2943 une Usual Residence of Decedent 10b. County unk item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director unk DC 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3001 Bladensburg Road NE 20018 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) housekeeping GSA Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Fred Pugh Inez Epson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. 203 N. St. SW; Apt 203; Washington, DC 20024 Ethel Gibson/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Zion Church Cem 2-19-10 Bedford, VA Mt. 4 □ Donation 5 🗷 Other (Specify) in state 21. Sign to of Funeral Service Licensee State Anatomy Board; 655 W. Baltimore Street Director Baltimore, Maryland 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ESPIRATORY FAILURE ⊉hysicia∩/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ARRHYTHMIA Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ၉ 1 Tes 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Medical 29a, Certifier Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. reh eller MD52855 2-2-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANDVER PARKWAY GREENWELT, MD 20170 KORAPATIM.D. CHANDKASEKHAR 31. Date filed (Month. 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

EThel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Phyllis M. Kowalke 0745 Aw 2010 0 05 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairfield Nursing Center Anne Arundel Crownsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 6/12/1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours 87 396-14-2615 Director Wisconsin Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f shov The Modical Examiner must be notified at 1 XYes 2 No Directo Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 933 Edgewood Rd., Apt. 107 21403 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. iit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene.
-rtant: if item 27 is marked other than "natural", or ite njury or other traumatic event, the Modical Examina. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 3 vears Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Herbert Carpenter Ann Kahr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth W. Kowalke/ Husband 933 Edgewood Rd., Apt. 107, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signate 1 A Sprice Licensee Kalas Crematory 2/8/10 Edgewater, MD permit.
Departr
Importa 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a no nsequence of): Examiner ypen Sequentially list conditions, if any, leading to immediate cause Filter Underlying Cause (Disease or injury Due to (or as a consequence Examiner ence of): the death certificate be executed burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ♣☐Pregnant at time of death 5 Other (specify) detached signed by the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🖳 NO 1 Yes 2 No 1 Tyes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Diractor: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred u atural 5 Pendina investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL PARKWAY ANNAPOLIS MO 2001 DAVIS, FEB 12 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorothy Simon Kraus  $P^{M}$ February 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Annapolis Ginger Cove Health Center Anne Arundel Social Security Number If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. Year 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2**x** Days Hours Months (Month, Day, Year, 286-10-6270 91 Director Őhio Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Anne Arundel Maryland 10c. City, Town or Location 10d. Inside City Limits Director Annapolis 1 🗌 Yes 2 🔀 No 10e. Street and Number 5202 River Crescent Drive 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXIo Specify: White Specify: Completed 3XXWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Real Estate Agent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Tillie Gottlob Alexander Jacob Simon 19a. Informant's Name/Relationship (Type, Print)
Kathy Sitte/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
474 Penwood Drive Edgewater, Maryland 21037 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Mem. Gardens 2/12/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Annapolis, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe.

Immediate Cause (Final disease or condition seattling in death)

a. Svdden Cardiac death Approximate Interval Between Onset and Death Physician/ minute disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner cue tially list our ditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed that initiated events physician ar s the burial-to resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires Records. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performe death? certificate 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ٥ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred After 5 Pending work n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fun 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted 3 📙 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print) Detense Hux, CHS 2 av

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23 a M 2010 Lincoln E. Kitchin 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Phota Medica harles Center La If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 1 X M 2 □ F Months Days Hours 74 July 15, 1935 Maine 005-30-9406 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Y Yes 2 No Charles Maryland White Plains 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3890 Stoneybrook Road 20695 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates; Na Vy 1 Never Married 2 X Married 1 ☐Yes 2 🕱 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computor Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esmond Kitchin, Sr. Lelia Hanson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Kitchin/ Wife <u> 8890 Stoneybrook Road, White Plains, MD. 20695</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Atlantic Crematory Feb. 19, 2010 Glen Bernie, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee 3035 Old Washington Rd. Waldorf, MD. 20601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Indeny mones disease or condition resulting in death) to (or as a consequence of) Orgeane Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 🗆 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

physician and s the burial-trans attending p cate has been signing page 2 should be certificate has funeral director, this Hospital or Attending death. nours after death.
neral Director: A
filled in by the fu 24 hours a

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

ð

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment, near the redifficility oncours.

**Physician** 

/Medical

Examiner

Physician/Medical

2

Completed

Be

Medical Certification: To

4 Thomicide

(Check only one)

29a. Certifier

Maryland 21215-0036

Baltimore,

completely within 2 2

Registrar

and manner stated 29b. Signature and title of certifie

determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

food, Suite 2034, Walder My 2002 ddress of person who completed cause of death (Item P3a) (Type, Print) Collin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Marylar Registrar	nd / Depa		ealth and	•	giene 201	0 05968
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Steve Kurak				2. Date of De Month Februa	eath ry 4, 2010	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or I			4c. County of D	
ı	Funeral Director		5. Social Security Number  475−20−1211  6. Sex 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			Birthplace (State or Foreign Country) Innesota
	aryland a-f show fied at	ector		ty, Town or Loc Rockvi					10d. Inside City Limits 1 ☐ Yes 2 To No
	rith the Ma 23a or 28 st be noti	ral Dire	10e. Street and Number 15020 Emory Lane		10f. Zip Code 20853			10g. Citizen of What	
9036	e filed within 72 hours after death with the Maryland ttal hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	ed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 1945		Was Decedent of His f Yes, specify Cuban	, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		
21215-0036	vithin 72 hou jiene. er than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+) 4	(Give k life. Do	dent's Usual Occupation of work done du O NOT use retired)	ining most of wo	orking	16b. Kind of Busine	Acquisition
ō	ild be filed within 7 Mental Hygiene. Iarked other than atic event, the Me	To Be	17. Father's Name (First, Middle, Last) William Kurak			18. Mother's Na ophia W		Maiden Surname)	
, Man	nd 2 should be settly and Ments n 27 is marked let traumatic e		19a. Informant's Name/Relationship (Type, Print) Stephen Michael Kurak/Son					er, City or Town, State, awnee, OK	
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)	Place of Dispos cemetery, crem Veteral	sition (Name of natory or other place ns Cemete:		b. 16, 2010	20c. Location - City Cheltenhaπ	or Town, State
Balt	permit. Departi Import any inj		21. Signature of Funeral Service License	22 F7 50	rancis 00 Univer:	Collin sity Bl	s Funera vd. W.,	l Home Inc Silver Spr	ing, MD 20901
	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Toronary Ar  Due to (or as a consequence)	tery Di		such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death 5 years
	Examiner	ıer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of the conditions).  Due to (or as a consequence of the conditions).	n					5 years
0	be existing siciar puris	ical Examiner	cause. Einter Onderlying Cause (Disease or linjury that initiated events resulting in death) Last  c						
. Box 6876	Attending Physician: The law requires that the death certificate be ex  # death certificate has been signed by the attending physician  for the funeral director, page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ls, P.O	uires that the signed by ald be detacted	þ	Part II. Other significant conditions contributing to death but not res Hyperlipidemia	ulting in the ur	nderlying cause give	n in Part I.			to the cause of death?  Probably 4 🗆 Unknown
Division of Vital Records, P.O.	idan; The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed					24a. Was autoj perfo 1 □ Yes	osy prior to death	autopsy findings available to completion of cause of ? Yes 2 \sum No
Vital	ysician; nis certific director,		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ YNo	ER/Outpatien	Other	ee of Death (Che		dence 6 Other (Sp	necify)
on of	ending Pl eath. or: After th the funeral	Certificate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be	28b. Time of injury	28c. Injury a work? M 1 □ Y	at es 2 🗆 No	28d. Describe h	ow injury occurred	
Divisi	ital or Att ins after d al Directu led in by t	al Certi	4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify	()			City or Tow		
	To the Hospital or Attending Physician: within 24 hours after deard. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my know only one)  1 Certifying Physician: To the best of my know only one)  3 Certifying Nurse Practioner: To the best of my know only one)	n and/or investi	gation, in my opinion eath occurred at the t	, death occurred time, date and p	I at the time, date a	nd place, and due to the	ne cause(s) and manner stated.
	5		29b. Signature and title of certifier  Paulog Cof M.D.		29c. License r	967]		29d. Date signed (Mo	nth, Day, Year) 12, 2010
			30. Name and address of person who completed cause of death (Item Pankaj Lal, MD 11119 Rockvi	lle Pik	ke, Suite	100, R	ockville	, MD 20852	
ļ	Stat Registra		31. Date filed (Month, Day, Year) FEB 16 2010 32. Registrar's Signar	. par	N. J.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Theresa KORENMAN <u>February</u> 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hebrew Home of Greater Washington
5. Social Security Number 6. Sex 7. Age (In yrs. last birth Montgomery Rockville Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) HERESA KORENHAN, EXPIRED FERRUMRY OT, 2010, 1 □ M 2 □ X F Months Days Hours Min. Director 079-28-2974 <u>March 14, 1908 Ukraine</u> Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County Director Prince Georges Beltsville Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 20705 3406 Stonehall Drive United States 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 7 is marked other than "natural", or items traumatic event, the Medical Examiner me 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) New York City and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Coilege (1-4or 5+) Welfare Department Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shlomo Zevalyon Shandell Rabinowitz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 3406 Stonehall Drive, Beltsville, MD Victor Korenman, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Lebanon Cemetery: 02/12/10</u> Adelphi, MD 21. Signature of Funeral Service Licensee Torchiniskysshebwew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT **Physician** /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and be exect Due to (or as a consequence of) Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23b. Was decedent pregnant in the past 12,months? 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 mon 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an autopsy performed certificate Division or Vital Hospitai or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation Injury n 24 hours after death.

he Funeral Director: A
inletely filled in by the ft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Nó Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 L/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY OF, 2010 leath (Item 23a) (Type, Print) 21 HONTROVE ROAD PIXEVILLE, MD 2085 Z 16

05969

3. Time of Death

4:30 A

10d. Inside City Limits 1 ☐ Yes 2 XNo

Birthplace (State or Foreign Country)

20012

Approximate Interval Between Onset and Death

Year

State Registrar

Medical

within 24 ho

To the Fune

completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05970 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MERRILL February 12, 2010 DONNALDSON KNIGHT III 6:33 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number Funeral 6. Sex 1 X M 2 □ F . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth August 10,1930 579-36-0319 Director 79 Virginia Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits North Potomac Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14720 Latakia Place 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc. ≥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced White Completed Specify: Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Vice President Insurance Company Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic according. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Merrill D. Knight II Alice Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June H. Knight (Wife) 14720 Latakia Place North Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 14, Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or): burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Fibrosis cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Yes 2 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Aguero 100 68080

Registrar
DHMH 17 Rev 7/2009

State

Center Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901; Medical

31. Date filed (Month, Day, Year) FEB 16 2010 Dr. Sireesha Jalli M.D. Rock ville MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0597 State
Registrar Amend#26. PerPhys. PGC2-17-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Day 100 2.00 PM Medical 010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OTOMAC FLOWERFIEL MONTGOMERY If Under 24 Hrs. 8. Date of Birth AMonth, Day, Ye 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Country) TRAN **Funeral** 1 □ M 2 💢 F Min Hours Director 8 RAN Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Markon F... 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Mov Bethesda MD 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 20814 2577 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lome maker Home /2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 10551EN ANISSALTANEH KHAKBA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOUDEH 13517 Flowerfield MOHSENI (DAUGHT) MD. 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 8/2010 Falls Church VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Aden Muslim Funeral Ler. soodbridge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician erebrovascular disease or condition Immediate Medical resulting in death) Due to (or as a consequence of): Examiner 20 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year signed by the ar Id be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy 24 hours after death.

Funeral Director: After this certificate leted filled in by the funeral director, pag 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Daughter's House Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home To Residence 6 X Other (Sp 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature And title of certific 29d. Date signed (Month, Day, Year) 12890 15/2010 and addless of person who completed cause of death (Item 23a) (Type, Print) )ISEMAN, M.D 5410 CONNECTICUT AVE. STE. 117 WASHINGTON ON M.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed

17

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F <i>rtificate of</i>			jiene 0	10	05972
		15	1. Decedent's Name (First, Middle, Las	t)	-			2. Date of Dea	th		3. Time of Death
	Physic /Medi		Woodrow Wilso	on Loveti	te			Februar	Day 19 20	Year	03:10A M
The second	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County		
			Envoy of Denton			Den			Car	coline	e
	Funeral		Social Security Number     6. Se	9x 7. Ag <b>X</b> M 2□F	e (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)		ace (State or Foreign
	Director		242-20-3440	AWZUT	97 Yrs.			June 4	1912	Nort	h Carolina
	death with the Maryland ms 23a or 28a-f show r.must be notified at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				10	d. Inside City Limits
	e Ma ta-f s	Director	Maryland Caroline	<b>e</b>	Greensbo	ro					1∭Yes 2 No
	th th or 28 e no	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Count	ry?
	23a ust b	la	601 N. Main Street	t		21	639		USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No-		- America k, White, e	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ██Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 I If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No		noun, oto.,	Specify.	T T1	ite
5-0	72 hc 'natur dical	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	oation during most of workin	na	16b. Kind of Bu	siness/Ind	ustry
121	12 should be filed within 'n and Mental Hygiene.' 7 is marked other than "raumatic event, the Mec	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5	mecha		d)		auto i	nduct	t was
d 2	filed Hygi Sther	ပ္တို	17. Father's Name (First, Middle, Last)		mecha	IIIIC	18. Mother's Name	(First, Middle, I			<u>-1 y</u>
an	ld be ental ked c	To Be	unknown				unknow			•/	
Z	shound M	-	19a. Informant's Name/Relationship (T	ype. Print)	19b. Maili	ng Address (Street	and Number or Rurai		r. City or Town.	State. Zip (	Code)
	nd 2 alth a 27 is r trau		Joanne Lovette/	laughter-i							
ē,	s 1 a if Hea item othe		20a. Method of Disposition	:	20b. Place of Dispo		Di		20c. Location -		
E	Pages nent of nrt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 🕅 Other (Specify	Removal from State ) Entombmen			Park Feb.	22. 201	0 Lexin	oton.	NC
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once.		21. Signature of Funeral Service Licens		2	2. Name and Addre					
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not en	ter the mode of dvir	U; Greensb ng. such as cardiac of	r respiratory arr	) 21639 est.		Approximate Interval Between
1	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. My	STITIAL		, Dista			Y	Interval Between Onset and Death MowTHS
	Examiner			Due to (or as	a consequence of):						
		Je.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of):						
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90,	e exe	E	resulting in death) Last	Due to (or as	a consequence of):						
68760,	ficate be executed physician and is the burial-transit	edical		d							
		/Me	IF FEMALE:	23c. If yes, outcome	of prognancy						
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mor	e of deliver nth [	y Day Year
	s that ned b		Part II. Other significant conditions co	ntributing to death be	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	pacco use contr	ibute to the	e cause of death?
or Vital Records,	equire en sig ould b	Completed by	DEMENTIA					1 □ Ye	es 2□No	3 Proba	ably 4 ∐Unknown
ဝ၁	law re as bec 2 sho	plet						24a. Was a		Vere autop	sy findings available
Ě	rsician: The law s certificate has t lirector, page 2 s	E O						autops perforr 1⊟ Yes	ned? d	eath?	pletion of cause of 2 🛣 No
ita	ilan: ertifica ctor, l	Be C	25. Was case referred to medical examiner?				26. Place of Death				-13110
ح ک	Physic this ce al dire	To	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatier	nt 3□ DOA Oth	er: 4 Nursing Horr	ne 5 🗆 Reside	ence 6 Othe	er (Specify)	)
O L	ding Pl h. After ti funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day		f 28c. Injur Worl	y at k?	8d. Describe ho	w injury occurre	ed	
sio	tendi eath. tor: A the fu	catio	2 ☐ Accident investigation			M 1 🗆	Yes 2 □ No				
Division	or At after d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubulding, etc	iry - At home, farm, sti c. (Specify)	eet, factory, office	2	Bf. Location (St. City or Town	reet and Numbe n, State)	er or Rural	Route Number,
	spital ours a neral filled		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, deat	h occurred at the tir	me date and place o	nd due to the e	oung(a) and may		
	To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination and/or in	vestigation, in my o	ppinion, death occurre	ed at the time, d	ate and place, a	and due to	the cause(s)
	To t	Σ	29b. Signature and title of certifier	1	443	29c. License		2	9d. Date signed	(Month, D	Jay, Year)
			Jeylu	/ ATTEM	UNG MD		53094		2-19-		0
			30 Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type,	Print)	1				
*		\	31. Date filed (Month, Day, Year)	WW 32 Damictor	LI ISLOOM	INGDAVE	MUE HER	WALS K	3 v2 ve, 1	UD	
	Sta Registr		FFR 22	2010	ar's Signature	PANCE					

10-01317 Richard H. Lee Please Type or Brint im Black Indelible Ink Engage AH/Qopins Are Legible 2010 05973
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	ate of ivial yland	-	tificate of D		Citaiii		eg. No.	, 0	000.
Physici Medical Exam		Decedent's Name (First, Middle Richard Henry Le						2. Date of Deat	h Day Yea		Time of Death
)		4a. Facility Name (if not institution 10703 Malone Street				City, Town, or Locat	ion of Death	February 1	4c. County o		1200 1113
Funeral Director			6. Sex 7. Ag	e (In yrs. la	ast birthday) If	Under 1 Year If t	Jnder 24Hrs ours Min	Accesses	h(MM/DD/YYYY) 8, 1944	9. Birth	olace (State or try) Maryland
l ow any		Usual Residence of Decedent 10a. State 10b. County  Maryland Mor	ntgomery	10c. City,	Town or Location	er Spring		1			0d. Inside City Limits
r death with the Maryland or items 23a or 28a-f show must be notified at once,	Director	10e. Street and Number 10703 Malone Str				f. Zip Code 20902		10	og. Citizen of Wh	at Country	
er death with , or items 23 r must be no	Funeral	11. Marital Status 1 X Never Married 2 X Ma 3 Widowed 4 Divo		Vie No	etnam If Yes, s	cedent of Hispanic pecify Cuban, Mexi	ican, Puerto		14. Race White		n Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f 5th or other traumatic event, the Medisal Examiner must be notified at once	Completed by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	or Dates:		16a. Decedent's U during most o		live kind of v		16b. Kind of Bus		ustry
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than numatic event, the Medisa	Be	17. Father's Name (First, Middle, Paul Coupard Lee	•					(First, Middle, M	laiden Surname)		
MD 21 d 2 should lth and Me n 27 is ma	To	19a. Informant's Name/Relationsh Marcelle Lee / I			767 Oak	Grove Circ	le, Sev	erna Park	, Maryland	2114	6
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the J		20a. Method of Disposition  1  Burial 2 Cremation  4 Donation 5 Other Spe	ecify:	te c	Place of Disposition rematory or other p Int Luke's (	lace) <b>Cemetery</b>	Febr	uary 27,	Feagavil	lle, M	laryland
		21. Signature of Funeral Service L		MO14		and Address of Fa y & Bastor Last Church				_	
Physician Medical Examiner		23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		hol:	intoxicat					1	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b.  Due to (or as a conse								
760, icate be executed g physician and the burial - transit	cal Exa	events resulting in death) Last  X UNPENDED	d.  AMENDED	equence or,	):						
68 certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr	23c. If yes, outcom 1 Live birth 4 Pregnant at	ne of pregn	2 Fetal de	eath 3 Ect	901 3/ opic pregna		23d Date of d Month	lelivery Day	Year
P.O. es that the igned by	<u>۾</u>	Part II. Other significant condition	ns contributing to death	but not re	sulting in the under	ying cause given ir	Part I	1 Yes		Probab	ly 4 Unknown
Division of Vital Records, P.O. Box ral or Attending Physician: The law requires that the death rs after death.  al Director: After this certificate has been signed by the atter led in by the funeral director, page 2 should be detached for u.	Completed							24a. Was an autops perform	y pri ned? de		sy findings available pletion of cause of
of Vitaling Physician After this cert	: To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 Inpatier	y	ER/Outpatient 3	DOA Other	Nursin	g Home 5 R	Residence 6		cene
Vision of or Attending Pher there death.  Director: After to in by the funeral	Certification:	Natural 5 Pendii 2 X Accident Invest 3 Suicide 6 Could	gation Fd Z/13/	10	Fd 12:00 me, farm, street, fac	1 Yes 2 tory, office building		riveway 28f. Location (St			n his Route Number, City
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined All Homicide 29a Certifier (Check only 1 Certifying Physics)	nined (Specify) ho resician: To the best of my iner:On the basis of exam				place, and		one St (s) and manner a	as stated	r Spring, M
To the with To to com	Medical	29b. Signature and title of certifier	and manner stated	indicit di	aror investigation, in	29c. License numb			29d. Date signed	d (Month,	
		30. Name and address of person w Margarita Korell MD.	rho completed cause of de Assistant Medical I		,	Street, Baltimo	ore, MD 2	21201	-		
St Regist	ate	31. Date filed (Month) Day Year)	2010 32. Redistrar	s Signatur	A hou	28					

10-01470 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edwin William Langdon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ February 18, 2010 1318 hrs Medical Examiner Edwin William Langton 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Calvert 8480 Chesley Drive Lusby If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Caminfornoa 05/21/1947 Director 288-42-3867 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location s 23a or 28a-f show e notified at once. 1 Yes 2 X No Calvert Lusby Maryland Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
rijury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20657 8480 Chesley Drive Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 1 X Yes Specify: White Unknown 1 Yes 2 No specify: 4 Divorced 3 Widowed If Yes, Give Year φ Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Resturant Chef Compl 18.Mother's Name (First, Middle, Maiden Surname) Anita Scherzer 17. Father's Name (First, Middle, Last) Benjamin Langton 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 8480 Chesley Dr. Lusby MD 20657 19a. Informant's Name/Relationship (Type, Print ) Sharon Kessinger - executor 20b Place of Disposition (Name of cemetery, Feb 24 2010 Metropolitan Funeral Service 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20c. Location - City or Town, State Alexandria Virginia 4 Donation 5 Other Specify 22. Name and Address of Facility Rausch Funeral Home Signature of Funeral Service License 4405 Broomes Is. Rd. Port Republic MD 20676 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line **IMedica** Death a Hypertensice atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and sician/Medical AMENDED 23a,27, permE, X UNPENDED g901 3/8/10 TT death certificate be 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Pregnant at time of death 5 Box 1 Yes 2 No 9 Unknown detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? O ģ 1 Yes 2 No 3 Probably 4 V Unknown pe i Completed 24b. Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy has death? performed? page 1 ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other Scene DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division thin 24 hours after death.
the Funeral Director: / 1 Yes 2 No 5 Pending 2 ___ Accident Investigation

00MF M. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

Medical

To the

3 Suicide

__ Homicide

29b. Signature and title of certifier

6 Could not be

determined

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City

February 19, 2010

29d. Date signed (Month, Day, Year)

or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#8, 18perFH, 2/19/10, BWW, McCertificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 02707/2018 FRANK GILMORE LEE, JR. 10:59 PM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) MD Age (In vrs. last birthday) 8. Date of Birtl4 - 7 - 51 **Funeral** 1 🗶 M 2 🗆 F Days Hours Min Months Director 220-54-4588 58 Usual Residence of Decedent show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Yes 2 No MD Montgomery Village Montgomery 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? marked other than "natural", or items 23a or matic event, the Medical Examiner must be Funeral with 9335 Chadburn Place 20886 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 No 1970-Black, White, etc. 1 Never Married 2X Married ģ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Specify: Black Completed 1972 Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Estelle Bowle Margaret Lee Bowle ೭ Frank G. Lee, Sr. other traumatic should be and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st ment of Health a tant: If item 27 is <u>Delores Lee - wife</u> <u>9335 Chadburn Place, Montgomery Village, MD 20886</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/18/10 All Souls Cemetery Germantown, MD 21. Signature of uneral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St. Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Hemorrhagic stroke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown detached 9 Unknown of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End stage renal disease cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 X Unknown Diabetes mellitus type II 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, I should be supported filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? Division 2 □ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa re and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anurita Mendhiratta

FEB 16 2010

31. Date filed (Month, Day, Year)

D38262

2401 Research Blvd, #330, Rockville, MD 20850

2/7/2010

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

	-	For State Registrar		State of Ma	aryianc		partment of I ertificate of I		a ivie	ntai Hy	giene Reg. No	201	0	05976
Physicia		1. Decedent's Name	, ,	,					2.	Date of De	ath		ear	3. Time of Death
Medic	al	Virgini 4a. Facility Name (if		tt Layton_			4b. City, Town, o	r Location of Do	ath	32	-/-	. County of	6	1250 M
Examin	er	Penysul		VAN MIDE	140	Cents	4b. City, lowil, o	Saushyn			40	Hich		00
Funeral		5. Social Security No	umber 6. S	ex / 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 H	in.	Date of Bir (Month, Da	av. Year)	1	Coun	
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items items		11. Marital Status	_	12. Was Decedent E Armed Forces?		13	. Was Decedent of H	lispanic Origin?	(Specify	Yes or No- an, etc.)		14. Race - A		
s arer cearn with the may rain ral", or items 23a or 28a-f show Examiner must be notified at	d b	1 Never Marri	ied 2  Married	1 ☐ Yes 2  If Yes, Give  Year or Dates.	Vo		1 ☐ Yes 2 🛣 No					Specify:	wh:	
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raums		19a. Informant's Na					iling Address (Street	and Number or	Rural Ro	oute Numbe	er, City o	r Town, State	e, Zip C	(ode)
Health Health Hem 27 Ther t		John La 20a. Method of Disp		Son)	20h Pla		Box 408 osition (Name of	Delma	r, D			ocation - Cit	ty or To	wn State
ent of nrt: If it		1 🗆 Burial 2		Removal from State	cei	metery, cr	ematory or other place y of Delma							Laware
permit rager and a should be may within a nous and Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exagone.		21. Signature of Fur		**	Joren		22. Name and Addre Short Fund			2010	De	Imal ,	рез	aware
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		23a. Part 1. Enter t shock, or hear Immediate Cause (		ofications that caused the cause on each line					liac or re	espiratory a	rrest,			Approximate Interval Between Onset and Death
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ing ph		IF FEMALE:		OCA Maria automa	of everyone									
attend for us	Physician/M	23b. Was decedent in the past 12 r 1 Yes 2	months?	23c. If yes, outcome of Live Birth 1 Pregnant at	2 🗌 Fetal	death 3	☐ Ectopic pregnan ☐ Other (specify) _	су				23d. Date of Month		ery Day Year
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igned l	þ	Part II. Other signif	icant conditions	ontributing to death bu	ut not resu	lting in the	underlying cause gi	ven in Part 1.		23e. Did 1		. /		ne cause of death?
been s	Completed									24a. Was		/\		psy findings available
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this ce al direc	은	1 ☐ Yes 2	₹No				ent 3 DOA Oth	4 ∐ Nursin				6 Other (5	Specify	)
th. After funer	ertificate:	27. Manner of Death  1 Natural 2 Accident	5 Pending Investigation	28a. Date of injur (Month, Day		28b. Time injury	wor	ryat k? ]Yes 2.∐No	28d	I. Describe	how inju	ry occurred		
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2	Medical Exam	visician: To the best of a niner: On the basis of ex se Practioner: To the l	amination	and/or inve	estigation, in my opini	on, death occurr	ed at the	time, date	and place	e, and due to	the car	use(s) and manner stated.
within To the	2	29b. Signature and		de l'Idelanon le die	odd or triy	raiowioago	29c. Licens	-	piaco, o	and due to the		ate signed (N		
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28/			ess of person who	completed cause of de	eath (Item 2	23a) (Type	, Print)		M.	lan a				
Stat	e	31. Date filed (Mont	ABZA AHA	010 32 Registra	72 <i>ALT)</i> r's Signatu	A MAY	Sales 299	LISBURY,	[ I IA	MYLAND	,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05977 State of Maryland / Department of Health and Mental Hygiene [] | [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Melhuish chard February 2010 0030 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital Center hester town Chester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □XM 2 □ F 65 252-74-5397 Director Pennsylvania July 16, 1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or other traumatic event, the Medical Evaniner must be notified at Funeral Director 1 Yes 2 No Greensboro Maryland Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 21639 United States of America 418_Bernard_Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1963-Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Caucasian Completed by 3 Widowed 4 Divorced 1966 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Officer State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ John Harold Melhuish, Sr. Margaret Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 Is any injury or other trauonce. 418 Bernard Avenue, Greensboro, Maryland 21639 William M. Melhuish Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 【 Cremation 3 ☐ Removal from State 2/19/2010 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory Dover, Delaware 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service License 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the diseasa or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attenam; within 24 hours after death. To the Funeral Director: Aft 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

FEB 22

31. Date filed (Month, Day, Year)

BUALO, MD

CHESTER RIVER HOSPITAL - 100 BROWN STREET CHESTERTOWN, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 01:03 a^M Geraldine Malice Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Locetion of Death Examiner Union Hospital Cecil Elkton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 10/30/1929 Delaware Director 222-16-8558 80 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Cecil Northeast 1 X Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 103 Edgewater Avenue 21901 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. δ 1 Never Married 2 Married 2 X No Maryland 21215-0036 nan "natural", Medical Exan If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry we filed wh... Mental Hygiene. '⊶d other than "r '≺, the M (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Non Profit Charitable Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ John Baker Helen Bolen traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 1 Ashen Sky Court Bear, DE 19701 Vincent Malice/Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Silverbrook Cemetery 02/24/2010 4 Donation 5 Other (Specify) Wilmington, DE 21. Signature of Inval Service Licensee 22. Name and Address of Facility 808 N. Union Street Corleto-Latina Funeral Home 11. Wilm, DE 19805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line nset and Death Immediate Cause (Final ₽hysician/ INFARCTION disease or condition resulting in death) MYOCHKDIAL Hours Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION DATS Sequentially list conditions. cause (Disease or iinjury Due to for as e consequence of physician and the burial-transit YEARS CORONARY AKTELY DISEASE that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be OBSTRUCTIVE PULLHOWARY YEARS DISEASE P.O. Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ☑ 9 ☐ Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has death? To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director; After this certificate h completed filled in by the funeral director, page 1 ☐ Yes 2 ☑ No 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 2 No ER/Outpatient 3 DOA မ 1 🗌 Yes 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury ■ Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physicían: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) NETHOOD MO 11,2010

DHMH 17 Rev 7/2009

State Registrar Suite #3

ELKTON MACYLAND

2192

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAWW GAK-EL

304-306 North Street

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Rita Joan Morgan 20 ใช้ 10:55 P™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Nursing Center Solomons Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 👿 F 0371571921 Rhode Island 084-12-1588 Director 88 Usual Residence of Decedent 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Calvert Dunkirk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 10321 Deer Trail Drive 20754 U.S.A. items ? 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: white 3 ¥ Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ္ Fatzie James Aloysius Grace Petronella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Dade, daughter 10321 Deer Trail Drive, Dunkirk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/19/2010 Baltimore National Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit Exami requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year ed by the a 1 ☐ Yes 2 ₩ 9 ☐ Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed Hospital or Attending Physician: The 2 No 1 Tes 25. Was case referred to medic examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending ithin 24 hours after death.

the Funeral Director: After ampleted filled in by the fun 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the l within 2 To the l 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type, drw)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

32. Registra

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osevelt Mack		State of Ma 1- For State Registrar 1. Decedent's Name (First, Middle, Last)	ryland / Department Certificate		Reg.  2. Date of Death	2010 No.						
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Baltimore permit. Pages 1 Department of H Important: If i		21. Signature of Funeral Service Licensee	$\frac{1}{2}$	2. Name and Address of Facility Se 451 Dares Beac	well Fun h Rd. Pr	neral Hom rince Fre	ie, P.A. d.,MD2067					
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E 6 Pi		4 Homicide determined (Spe 29a, Certifier 1 Certifier Physicians To the		curred at the time, date and place, and	or Town, State		-					
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the b		gation, in my opinion, death occurred a								
	ž	29b. Signature and title of certifier	Tell most	29c. License number O.C.M.E.		ebruary 14, 2010						
ew I	Ì			Dan Chart Delli 120	24204							
(W)		30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

		For State	State of Maryl				nd Mental	Hygier	ne 201	0 05981
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ith with ms 23 must	Funeral	446 Sarah Anne		ua Irai	207				U.S.	Α.
Maryland 21215-0036  should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	d by Fi	11. Marital Status  1 Never Married 2 💢 Married 3 Nidowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates.	1:	Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2 🔀 No	n, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	ite, etc.
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Baltimo		31. Signature of Funeral Service Licens	Mula	/	Name and Addres		Rausch	Funer	al Home	. P.A.
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the Hosp thin 24 ho the Fune mpleted fi	Medical	only one) 3 Certifying Nurs	ician: To the best of my kno ner: On the basis of examina e Practioner: To the best of	tion and/or investi	gation, in my opinion	death occur	red at the time dat	te and place	a and due to the	cause(s) and manner stated
<b>5</b> ≥ <b>5</b> 8		29b. Signature and title of certifier	Krieger IN	10	29c. License	-838	<i>y</i>	29d. Da	ate signed (Molit	h, Day, Year)
XW 8		SUSAN H. KRIE	ompleted cause of death (it	145 D	efense i	Hwy	Acron	apol	is, mes	21401
Sta Registra		31. Date filed (Month, Day, Year)	6 2010 Census	nature	barker	7				
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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		For		S	tate of	Mar	yland	d / Dep	artment	of H	lealth a	and M	lental Hy	gien	e	1.0	05000
		State Registrar						Cei	rtificate	of L	Death			Reg. I	10.ZU	IU	05982
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		Charlott									tte H				St. M		
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and show lat	ō	10a. State	10b. County			10	Oc. City,	Town or Lo	cation							1	0d. Inside City Limits
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should and h is ma	ш	19a. Informant's Na	me/Relationshi	p (Type, P	rint)			19b. Maili	ng Address (	Street a	and Numbe	r or Rura	Route Number	r, City	or Town, S	itate, Zip C	Code)
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e 1 a t of H if ite or oth		20a. Method of Disp 1 ☐ Burial 2X		3 ☐ Remo	oval from S		_ce	metery, crei	osition (Name matory or oth	er plac	e)		ate		Location -	,	
t. Pag tmen tant: jury o		4 Donation	5 Other (Sp	ecify)			Ka		remato		:_	2/6/			dgewa		
perfit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Innoctants if time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fun	peral Service (1)	censee									rge P.				
422 (0 0)	2973 So1omons Island Ro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator												gewat	er, l			
			t failure. List or		use on eac	h line.							respiratory arr	est,			Approximate Interval Between Onset and Death
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to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical		☐ Medical Ex	aminer: C	n the basis	of exam	nination	and/or inves	tigation, in my	opinio y	n, death oc	curred at		nd plac	ce, and due	to the cau	ise(s) and manner stated.
ompl	Σ	only one) 3 29b. Signature and t	Certifying i	Nurse Pra	ictioner: Id	the bes	it of my l	knowledge,			number	and place			e(s) and ma ate signed		
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	Physicia	ın/	1. Decedent's Name (First, Middle, Las	,				2. Date of Deat	h Day H Ye	3. Time of Death
	Medic Examin	cal	Alfredo Martinez-l 4a. Facility Name (if not institution, give				Location of Death	1-tbirk	4c. County of E	
	Funeral		Baltimore Washing  5. Social Security Number   6. S		Center	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Ann	Birthplace (State or Foreign
	Director		580-24-8718 Usual Residence of Decedent	XXM 2 □ F	77 Yrs.	Months Days	Hours Min.	^{(Manth} 2 ^{Day} 1	932	Puerto Rico
	yland f show ed at	ctor	10a. State 10b. County MD Anne Art		0c. City, Town or Loc					10d. Inside City Limits
	the Mar or 28a- e notifi	Dire	10e. Street and Number	under	-	Severn 10f. Zip Code		1	l0g. Citizen of What	1 ☐ Yes 2 X No t Country?
	th with the ms 23a must b	Funeral Director	8100 Walton Rd.				21144			USA
3036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.  27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 45 Divorced	12. Was Decedent Ever Armed Forces? 1★★ Yes 2 □ No If Yes, Give Year or Dates.	Korean	/as Decedent of His Yes, specify Cubar XXYes 2 □ No			Black, W	American Indian, White, etc. White
Maryland 21215-0036	vithin 72 hou iene. r than "nati the Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give k	ent's Usual Occupa ind of work done di NOT use retired) nasing Ma	uring most of work	ing	16b. Kind of Busine	ess Industry
/land ?	d be filed v Vental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Buenaventura Mar				18. Mother's Nam	, .		1001
	1 and 2 should by Health and I litem 27 is maid other traums		19a. Informant's Name/Relationship (T Lydia Santiago	ype, Print) Sister		g Address (Street a Walton Rd	nd Number or Rura Sever	n, MD 21	City or Town, State 144	, Zip Code)
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Conten	Removal from State	Maryland V	atory or other place Veterans	Cem 2/16	/2010	20c. Location - City	ille, MD
Bail	permit Depart Impor any in		21. Signature of Funeral Service-Licens	~	12	2 Ridgely	Ave. A	nnapolis	neral Hor , MD 2140	
ŗ	nysician/	8 3	23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition	plications that caused the ne cause on each line.				,	inomo	Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a co	unsequence of,.					
9	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a co	onsequence of):					
BOX 68/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of page 1  Live Birth 2  4  Pregnant at tire 9  Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
IS, P.O.	uires that th n signed by uld be detac	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob		e to the cause of death?
Hecords,	The law req ate has bee page 2 sho	Completed						24a. Was ar autops perforn 1 \sum Yes 2	v prior	
VITAI	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:		_ Other	ce of Death (Check	only one)		
on or v	nding Physath. ath. After this e funeral d	Certificate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye	2 ER/Outpatient 28b. Time of injury	28c. Injury work?	at	me 5 ☐ Reside 28d. Describe ho	nce 6 Other (S) w injury occurred	oecify)
DIVISION	tal or Atte rs after de al Directo led in by th		3 □ Suicide 6 □ Could not b 4 □ Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, stre Specify)	et, factory, office		28f. Location (Str City or Town,		Rural Route Number,
	e Hospi 124 hou e Funer bleted fil	Medical	(Check 2 Medical Exami	sician: To the best of my ner: On the basis of exam se Practioner: To the bes	nination and/or investi-	gation, in my opinior	n, death occurred at	the time, date and	d place, and due to t	he cause(s) and manner stated.
	FILA.	<	29b. Signature and title of certifier	/ ( W	77	29c. License	number 8-00 f	29	9d. Date signed (Mo	onth, Day, Year)
-	341VA		30. Name and address of person who c	completed cause of death	h (Item 23a) (Type, Pr	int)	Doc.	(2) Lu	1 Bar	nie, ms
-	Stat Registra	e	31. Date filed (Month, Dev Pear) 2 2	010 32. Registrar's	Signature	Sarked	0 7	<b>V</b> ) 1		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 7 ELLEN MARCIL 2340 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 - M 2 7 F Min. JULY 3, Year 1932 77 **Director** 577-40-2220 Yrs WASHINGTON, DC Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 582 PINEDALE DRIVE 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ò 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **ARCHITECTURAL** Elementary/Seconday (0-12) College (1-4 or 5+) CONTRACT SPECIALIST DESIGN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F LESTER BOYD SWINK, SR. JESSE GWYN SPATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: litem 27 is a any injury or other trainingnee. 582 PINEDALE DRIVE, ANNAPOLIS, MARYLAND 21401 ROGER B. MARCIL 20b. Place of Disposition (Name of FORTILINGOLN)

TORRESPONDENCE Place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State FEBRUARY 9, 2010 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 Will Elmin M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be d ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performed 2 No Yes 2 N 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 24 hours after death. Funeral Director: A 1 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | To the I within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie DEFENSE HIGHWAY ANNAPOUS MOLIYOF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

**Division of Vital** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 24a per phys. 6901 3/22/10 dk State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Feb. 11, **Physician** Month 2010 12:40 PM Joseph J McLaughlin /Medical 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Clinton Prince George's Southern Maryland Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 16, 1941 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral ™**M 2□ F 68 Yrs. Washington DC 578-54-0144 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Examination and the retified a Director Upper Marlboro 1 □Yes 2 ▼No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 20772 5205 Roblee Drive Funeral USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 SYes 2 No
If Yes, Give
Year or Dates: 1963–1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2000 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Dwight McLaughlin Elizabeth Marie Thomas ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Shirley McLaughlin - Wife Upper Marlboro, MD 20772 5205 Roblee Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Suitland, MD Washington National | Feb. 18,2010 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Rd, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final **Physician** Myocardiel Immediate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely life in by the funeral director, page 2 should be detached for use as the burial-transit completely life in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Vital 1 ∐Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40216 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Oxen Hill Rd \$704 Oxon Hill, MD 20745 6188 ullen Rnnis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 17 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 5 per FH G901 3/24/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month February Day 13, Robert Julius 2010 Myers 11:35 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town, or Location of Death 4c. County of Death 9610 Wire Avenue Silver Spring Montgomery 5. Social Security **1779** 217-32-0120 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Year)1912 1 🕱 M 2 🗆 F Months Days Hours oct. 31. 97 Director Pennsylvania Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9610 Wire Avenue 20901 USA 12. Was Decedent Ever in U.S. Armed Forces?

Yang Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3X Widowed 4 □ Divorced Completed WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Actuary Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Lawrence Myers Edith Hirsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan K. Myers/Son 1981 Ridley Creek Road, Media, PA 19063 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Febio16 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090 Signature of Funeral Service Licepe 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retwee Onset and Death

14 months Immediate Cause (Final Physician, Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure, COPD 1 Yes 2 k No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 \(\int\) No this certificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 🗆 Yes 2 😾 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work? 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ⚠ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Le Joll 15+1 mo D22309 February 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip W. Poth, MD 8712 Maywood Avenue, Silver Spring, MD 20910

State

Registrar

31. Date filed (Month, Day, Year) **FEB 16 2010** 

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 08. 6:25 am 20T0 Ruth Goodin Moss Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Mitchellville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Days 09/26/192 Hours Min. **Director** 252-36-4159 88 Kansas Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State should be filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11508 Coral Root Court 20721 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black. White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Prince George's County marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. School Teacher Public Schools System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Winfield Goodin Lillie Bell Reunolds and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra John E. Moss, Jr. <u>- Son</u> 11508 Coral Root Court. Mitchellville. MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 02/18/2010 Arlington, Virginia Arlington Natl. Cem. 21. Signature of Funeral Service Lice ise 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Mc #1070 N 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, Ischemic Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Cardiovascular Disease Years squentially list conditions Esque itany list conuntoris, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Debility Years the burial-tran attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Dav Pregnant at time of death Yes 2 X No ate has been signed by the page 2 should be detached q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? 1 Yes 2 No Yes 2 X No Be ( 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 🕅 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 28a. Date of injury (Month, Day, Year) s after death.

al Director: After th 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29d. Date signed (Month, Day, Year)

Registrar

State

10

14300 Gallent Fox Lane, Suite 222, Bowie, Maryland 20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD,

Rakesh Arora,

3 16 2010

			For State Registrar	State of Ma	aryland /	Depa <i>Cer</i>	artmen <i>tificat</i>	t of He	ealth a Death	ınd Me		giene Reg. No.	/	059	886
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of Dea	ath		3. Time of	
-	/Medi	cal	Alberto Moreno  4a. Facilify Name (If not institution, give s	troat and number)			4h City	Town or	Location o		Februa		1, 2010	5:22	A M
7	Examir	ier	21148 Camomile Cou				_	nanto		Death			ontgomer	У	
	Funeral Director		5. Social Security Number 6. Sex		e (In yrs. last b	oirthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Nov • T	h	9 Rintho	lace (State o try) ragua	r Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside Cit	ty Limits
	Maryla a-f sho fied at	tor	Maryland Montgome	ry	Germa									1 □Yes	-
	or 28s	Director	10e. Street and Number		l		10f. Zip	Code				10g. Citiz	zen of What Coun	try?	
	ath w		21148 Camomile Cou			1		20876					ted Stat		
920	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ★ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent! Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Deced fYes, sped I⊠Yes				cify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: WI		
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natui he Medica!	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5		(Give life. [	lent's Usua kind of wo DO NOT us	rk done di se retired)	uring most		g		nd of Business/Ind	·	
2	filed w Hygie other t		17. Father's Name (First, Middle, Last)			Ma	chine				(First, Middle,		urance C	ompany	<del>/</del>
/lan	Jental Jental rked o	To Be	Francisco G. Mor	eno							ierrez	Was Borr	oomano,		
Mary	ages 1 and 2 should be nt of Health and Mental t; If item 27 Is marked o / or other traumatic eve		19a. Informant's Name/Relationship (Type Maylu Moreno, Daug	,									r Town, State, Zip , MD 208		
more,	Pages 1 annent of He ant; If item		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		of Dispo ery, cren ropo emat	311 ta	ne of other place <b>N</b>			ary 16		cation - City or To		nia
Balti	permit. Page Department Important; fl any injury o		21. Signature of Funeral Service License	ber		22	. Name an		s of Facility	y D		uner	al Home hersburg		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations hat caused e cause on each lir	I the death. Do	not ente	er the mod	le of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Bet	e ween
	Physician /Medical	Ĥ	Immediate Cause (Final disease or condition resulting in death)	Pancrea										Onset and [	Jeath
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8760,	icate be executed physician and s the burial-transit		J ,	Due to (or as	a consequence	e 01).									
P.O. Box 6	ath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deal		Ectopic pr Other (sp					2	23d. Date of delive Month		/ear
	tw requires that the despensions to be some signed by the second to be detached to	þ	Part II. Other significant conditions con	tributing to death bu	ut not resulting	in the ur	iderlying o	ause give	n in Part I.			obacco u	se contribute to th	ne cause of d	
or Vital Records,	ي ۾ ف	Completed									24a. Was autop		24b. Were auto prior to con death?	psy findings and pletion of ca	available ause of
tal	ician: Th certificate rector, pag		25. Was case referred to medical						26 Place	of Dogth	1 Yes (Check only o	2 <b>\D</b> No		2 □ No	
>	Physician: r this certific ral director,	To Be	examiner?	ospital: 1 ☐ Inpatie	nt 2 ER/C	outpatien	t 3 🗆 DC	Othe					S □Other (Specif	v)	
ion o	Attending Ph r death. ector; After th by the funeral		27. Manner of Death  1 ☒ Natural 5 ☐ Pending investigation	28a. Date of Inju (Month, Da)	ry 28b.	. Time of Injury	M 2	8c. Injury Work 1 □ Y		28	8d. Describe h				
Division	al or Attendates after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuliding, etc		farm, stre	eet, factory	, office		28	8f. Location (S City or Tou	Street and vn, State)	d Number or Rura )	l Route Num	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 A Certifying Phys (Check only one) 1	ician: To the best of er: On the basis of and manner sta	f examination a	ge, death and/or inv	occurred vestigation	at the tim	e, date an	d place, a	nd due to the ed at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s	3)
	Vithin To the Comple	Ž	29b. Signature and title of cepifier				290	D6	number 6990				e signed (Month, uary 12,		
			30. Name and address of person who cor Vinni Juneja, M.D.	, 6420 Ro	ockledg	e Dr	ive,	#410	О, Ве	ethes	da, MD	208	17		
	Sta Registr		31. Date filed ( <i>Month, Day, Year</i> ) <b>FEB 1.6</b> 2010	32. Registra	ar's Signature	far	KI								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Temp Molloy February 2010 8:30 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3214 Paul Drive Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Dec. 31 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 F Hours Country)
Wisconsin Director 390-16-0063 Yrs. 89 Dec. 1920 Usual Residence of Decedent shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 3214 Paul Drive 10f. Zip Code 10g. Citizen of What Country?
USA 20902 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. ğ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within : Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M ginee. Elementary/Seconday (0-12) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Rudolph Temp Jennie Lund 19a. Informant's Name/Relationship (Type, Print) Nancy Crawford/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4132 Danube Court, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. 18 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 2010 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 Months Immediate Cause (Final Melanoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To Be Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🔁 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ★ Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signatyre and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D45956 ville February 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dawn Broderick, MD 18109 Prince Philip Drive, #275, Olney, MD 20832

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/AMEND#26perMD, 2/16/10, BMV, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DeLeon February Louis Mendez 2010 10:23 a M Medical 4a. Facility Name (if not institution, give street and number)
Washington Adventist Hospital Examiner 4c. County of Death Montgomery 4b. City, Town, or Location of Death Takoma Park Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Dominican Republic 56_{Yrs.} 577-78-0048 June I, 1953 1 □**x**M 2 □ F Months Days Hours Min. Director Usual Residence of Decedent show the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Prince George's **Hyattsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 2703 Kirkwood Place, Apt. 201 20782 Dominican Republic 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1¾ Yes 2 □ No Specify:Dominican Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ricardo DeLeon Maria Adelina Mendez -Wife 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Mumbes or Rutal Route Number, City of Town State Spring, MD 209 6 Blanca Lillian DeLeon Thompson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 1 2010 20c. Location - City or Town, State 15, 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 3  $\square$  Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ned by the a 2 🗌 No Yes ate has been signed by page 2 should be detac contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Diabate Yes 2 No 2 🗌 No 1 Yes ours after death.

Neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA me 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No М Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af ... To the Funeral Di completed filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) # 216. Rockville. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 5, Burnell McClenny 2010 5:55 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 🗆 F Months Days Hours Min. Feb. 22, 1919 Director 223-10-8601 90 Virginia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 St. Lawrence Drive 20901 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Se Yes 2 No
If Yes, Give 19
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1941-61 Specify:White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Seconday (0-12) Officer US Army Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Robert L. McClenny Minnie Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 St. Lawrence Drive, Silver Spring, MD 20901 Anne McClenny/Wife Baltimore, 20a. Method of Disposition March 22, 2010 20c. Location - City or Town, State cemetery, crematory or other place)
Arlington National
Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington, Virginia Signature of Funeral Service Licens Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 um 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Aspiration Pneumonia Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year Yes 2 No 9 Unknown g Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' 2 🗌 No Yes 2 X No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: မ 1 Tes 2 🙀 No Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending (Month, Day, Year) injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) D66249 February 5, 2010 12+1 . 1

State Registrar 31. Date filed (Month, Day, Year) FEB 16 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Duran, MD 1500 Forest Glen Road, Silver Spring, MD 20910

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar	Cei	rtificate of D		_	giene Reg. No. 201	0 05992
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Jorge	Martin			2. Date of De Month Februa	ry ^{Day} 2, 201(	3. Time of Death 2:51 P M
	Examir		4a. Facility Name (if not institution, give street and number) 435 W. Diamond Avenue, T-3		4b. City, Town, or Gaithers			4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 7. A. 1 M 2 G F	ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Aug • 24	th 9 Bi	rthplace (State or Foreign ountry) Cuba
	show d at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			,	10d. Inside City Limits
	r 28a-f notified	Direct	Maryland Montgomery  10e. Street and Number	Gaithers					1 X Yes 2 ☐ No
	n with th	<b>Funeral Director</b>	435 W. Diamond Avenue, T-	3	10f. Zip Code 2087	7		10g. Citizen of What C United Stat	-
9600	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  If Health and Mental Hygiene.  The marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 🛣 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces 1 □ yes 2 ☒ If Yes, Give Year or Dates.	No.	Was Decedent of His If Yes, specify Cuban	Specific	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
215-(	n 72 ho e. an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or	(Give	dent's Usual Occupa kind of work done du O NOT use retired)	ition uring most of worki	ng	16b. Kind of Business	Industry
d 21	ed withi Hygiene other th	Be Co	12 - 17. Father's Name (First, Middle, Last)	J+)	Printer	40. 14-111-11		Insurance	Company
Maryland 21215-0036	ild be fil Mental narked atic eve	2	Domingo Martin			18. Mother's Name Herminia		,	
Mar	d 2 shoualth and 27 is mer		19a. Informant's Name/Relationship (Type, Print) Miriam Ferraro (Daughter)					r, City or Town, State, Zi	
			20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo		Febru	ary 15	20c. Location - City or	Town, State
Saltii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral S Aice Licensee	Creñ	<b>natory</b> I. Name and Address	i 201 s of Facility De	Vol Fun	Alexandria eral Home,	
	<u> </u>	_	23a. Part A Enter the disease, or complications that cause		O E. Deer er the mode of dying	Park Dr , such as cardiac o	ive, Ga	ithersburg	MD 20877 Approximate
	nysician. Medical		23a. Part A Entre the disease, or complications that cause enocut or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	o. INIC IS	CHEMIC	HEAR	IT DI	SEASE	Interval Between Onset and Death
	Examiner	_	Due to (or as  Di A	PNIC IS a consequence of): BETES	MELLIT	us			
	unsit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a consequence of):					
	incate be executed by physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last c. Due to (or as	a consequence of):					
0/0	ng physi as the t		IF FEMALE:						
o you	within 54 hours after death.  Within 54 hours after death.  The Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use	Physician/I	23b. Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
7.	es man resigned b	2	Part II. Other significant conditions contributing to death b	out not resulting in the un	nderlying cause give	n in Part I.		bacco use contribute to	
ecords,	w requires tr	Completed					1 □ Y	n 24b. Were au	robably 4  Unknown topsy findings available
בי ק	icate has						autops perfor 1 \(\sigma\) Yes	med? death?	completion of cause of
VIC	inscertifications of director, p	o Pe	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  Hospital: 1 ☐ Inpati	ent 2 DER/Outpatien	Othor	e of Death (Check		ence 6 Other (Spec	ifu)
5 10	ath. : After the funeral	· ·	27. Manner of Death  1 M Natural 5 Pending 2 Accident Investigation  28a. Date of inju (Month, Da)	ry 28b. Time of	28c. Injury a work?			ow injury occurred	
	ours after deat ours after deat eral Director; filled in by the	al Certificate	3 Suicide 6 Could not be	ury - At home, farm, stre			8f. Location (St City or Town	reet and Number or Rui n, State)	ral Route Number,
Tool o	the Funer the Funer mpleted fill	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of Medical Examiner: On the basis of e	xamination and/or investi	gation, in my opinion.	death occurred at t	he time date an	d place and due to the	cauca(e) and mannor stated
t _t	comp		29b. Signature and title of confifer		29c. License n	number	2	29d. Date signed (Month	, Day, Year)
			30. Name and address of person who completed cause of d Herbert Juarbe, M.D., 806 N	eath (Item 23a) (Type, Pr	rint)				
<u>Q.).</u>	State Registra		B1. Date filed (Month, Day, Year) FEB 16 2010	ar's Signature	W.				

		For State Registrar	State of Maryland / D	epa Cer	rtment of H tificate of D	ealth ar leath	nd Me		ene 201	0 05993
Physicia Medi		1. Decedent's Name (First, Middle, L Mary Therese I	ast) Manger					2. Date of Death Month Februar	1	3. Time of Death 1.45 a M
Examir		4a. Facility Name (if not institution, gi Holy Cross Hosp:			4b. City, Town, or Silver				4c. County of D	eath Cgomery
Funeral Director		214-22-9831	Sex 1 ☐ M 2 ☐ 7. Age (In yrs. last birth 83	day) 'rs.	If Under 1 Year Months Days			B. Date of Birth Aug. 7,	^{Yea} 1926 N	Birthplace (State or Foreign Country) laryland
aryland a-f show fied at	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Me	10c. City, Town		ation er Spring					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the M 23a or 28 ist be noti	eral Dir	10e. Street and Number  131 Fleetwood	3	TTV	10f. Zip Code	0910		11	Og. Citizen of What	
Iryland 21215-0036  ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status  1 □ Never Married 2 🙀 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?	lf	/as Decedent of His Yes, specify Cuban ☐ Yes 2 ▼No	panic Origin , Mexican, P	n? (Speci: Puerto Ri	fy Yes or No- can, etc.)		merican Indian, hite, etc. White
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exami	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)	Education 16a. [ Trade completed)  College (1-4 or 5+)	Give ki ife. DC	ent's Usual Occupa ind of work done du NOT use retired) emaker	tion uring most of	f working	()	6b. Kind of Busine	
Maryland 2 2 should be filed v th and Mental Hyg 27 is marked oth traumatic event,	To Be	17. Father's Name (First, Middle, Last Harry F. Curley	)					First, Middle, Ma Thomas	aiden Surname)	
Ma 12 shullth ar 27 is r trau		19a. Informant's Name/Relationship John Thomas Mar	Type, Print) nger, Jr./Husband	Mailing 131	Address (Street ar Fleetwo	nd Number o	or Rural F	Route Number, (	City or Town, State, er Spring	Zip Code)
Baltimore, permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Metrop Metrop	oli	tan Crem	atory	Fe 20.	10 12	Oc. Location - City Alexandr	ia, VA
Bal permi Depa Impo any ir	8	21. Signiture of uneral Service ice	0							ing, MD 20901
Physician/ Medical		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	, such as car		espiratory arres	t,	Approximate Interval Between Onset and Death			
Examiner	ner	Sequentially list conditions, If any, leading to manufacture cause. Enter Underlying	Due to (or as a consequence of Pleural Effusion b.							
certificate be executed nding physician and use as the burial-transit	edical Examin	Cause (Disease or imigury that initiated events resulting in death) Last	Atrial Fibrillat  c. Due to (or as a consequence of Anemia							
BOX 68 death certifi he attending ed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2x No 9 Unknown	23c. If yes, outcome of pregnancy  1	3 🗆 5 🗆	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year
cords, P.O. law requires that the has been signed by the could be detach	by	Part II. Other significant conditions	contributing to death but not resulting in	the un	derlying cause give	n in Part I.				to the cause of death?  Probably 4  Unknown
Hecords, The law requires cate has been sig	Completed							24a, Was an autopsy perform	ed? prior t	autopsy findings available o completion of cause of ? /es 2  No
r Vital Physician: this certific al director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 XNo  27. Manner of Death	Hospital:		3 DOA Other	4 L Nursi		· · · · · · · · · · · · · · · · · · ·	ce 6 Other (Sp	ecify)
DIVISION OF VITAINED TO THE HOSPITAIN THE WITHIN 24 hours after death.  To the Funeral Director. After this certificate in gompleted filled in by the funeral director, page	Certificate:	1   Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not	be 28a Place of Injury At home form	Jry		at es 2□No	0	-	injury occurred	
Spital or A		4 ☐ Homicide determined	building, etc. (Specify)  ysician: To the best of my knowledge, de			tate and plac		City or Town,	State)	Rural Route Number,
<b>To the Ho</b> within 24 I <b>To the Fu</b> pompletec	Medical	Check Z L Medicai Exan	niner: On the basis of examination and/or in real Practioner: To the best of my knowled	nvestic	iation. In my opinion	, death occur time, date an	rred at the	e time, date and and due to the ca	place, and due to th	e cause(s) and manner stated, as stated.
15		30. Name and address of person who	completed cause of death (Item 23a) (Ty	pe, Pri	D60826				'eb. 12,	
Stat		Kshama Garg,	MD 1500 Forest G	len	Road, Si	ilver	Spri	ng, MD	20910	
Registra	ar	LED 10 5	32 Registrar's Signature	Par	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Ronald Francis Minnick Medical 4b. City Jown, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner g. Birthol 8. Date of Birth 7. Age (In yrs. last birthday) Sex 1 M 2 □ F Social Security Numbe Mary Land **Funeral** 07-29-1968 41 220-78-7525 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Mt. Savage Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21545 13517 Blank Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black White etc. Armed Forces 1 Yes 2 No 1 Never Married 2 Married Completed by "natural", or 1 Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Melical! 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Construction 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Shirley K. Platter Decker James B. Minnick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13517 Blank Road Mt. Savage, MD 21545 Shirley Decker mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 03-01-2010 Frostburg, MD Frostburg Mem Park 22. Name and Address of Facility Sowers Funeral Home, Signature of Funeral Service Licensee 60 W. Main St., Frostburg, MD 21532 1an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 18/060 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Year Month Day in the past 12 months? g Unknown sate has been signed by the space 2 should be detached: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No After this certificate | 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Medical Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 4 ☐ Homicide determined 1 Y Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar only one)

LUDHEER LANKOULU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ھا 7 Registrar's Signatu

12500 Willowbrook

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT WILSON McCLYMENT  $\mathbf{A}^{\mathsf{M}}$ FEBRUARY 16,2010 9:28 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HEARTLAND HOUSE QUEEN ANNE'S GRASONVILLE 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
DEC . 27 , 1918 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Director Yrs MARYLAND <u> 216-14-2751</u> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD QUEEN ANNE'S GRASONVILLE 10e, Street and Number 10g. Citizen of What Country? Funeral 300 CEMETERY ROAD 21638 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 

No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 1941-1945 WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 HIGHWAY SUPERVISOR STATE ROAD DEPT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM ANDREW MCCLYMENT ESTHER CARRIE CAPEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8534 BRIAR PATCH DRIVE, DENTON, MD 21629 WANDA HARMON/ DAUGHTER 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or of once, 20c. Location - City or Town, State FEB. Date 19 cemetery, crematory or other place) CHESTERFIELD CEMETERY 2010 4 ☐ Donation 5 ☐ Other (Specify) CENTREVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
408 S. LIBERTY ST., CENTREVILLE, MD 21. Signature of Funeral Service Licenses 23a Part 1. Enter the dis e, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause or Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequenc 1 of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death IF FEMALE: asn 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year ed by the a 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Pesidence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending Accident M 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. othe Hr within 2 29b. Signature and title of certi-

State Registrar ame and address of person

31. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BOWYEN

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:21 Am February 15, 2010 Henrietta Liggett Mesnard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F 578-20-7906 91 September 12,1918 Wardensville, WV Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience in ust to nother at 10a State 1 X Yes 2 □ No Director Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 3500 Lancer Drive 20782 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department Elementary/Secondary (0-12) College (1-4or 5+) Secretary Interior 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warden Liggett Leah Shobe ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar James M. Mesnard / Son 3716 Green Ash Court, Beltsville, MD 20705 Item 27 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 nent of H ant: If Ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 2/22/2010 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Ay Rugens Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Approximate Interval Between Onset and Death . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Aspiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebral Uscalar accident Poute Tholoraic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 X No 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ☐ ER/Outpatient 3 ☐ DCA 1 Inpatient Medical Certification: To this. 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.
e Funeral Director: A letely filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 ho

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completely f (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 2010 Physician D61067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12520 Prosperity Drive Suite 320 Silver Spring, MD 20904 KHANDAGUE, MO 32. Regist, ir's Sign stur 31. Date filed (Month, Day, Year) State 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05997 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:15 ROLAND L. MILLS Feb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset 14219 Carver Manor Circle <u>Eden</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🕱 M 2 🗆 F Months Hours Min. sept. Day Ye 1950 Maryland <u>217–52–00</u>18 **Director** 59 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Somerset Eden 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? USA Funeral 21822 14219 Carver Manor Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 No Black, White, etc. δ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white If Yes. Give Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer State 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Janet Hancock Roland L. Mills permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 West Main St., Crisfield, MD 21817 <u> Kelly Garpstas (daughter)</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 2 19 10 Hebron, MD Scringhill Memory Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License HO I TOWAY Funeral Home, Professional Association 501 Snow Hill Road, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown s been signed by the should be detached P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 21 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) Hospital 2 🗌 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12010 D 45098

Registrar

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HALL HIGHWAY, CRISFIELD, MD, 2181

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32 Registrar's Signatur

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31. Date filed (Month, Day, Year) FEB 16

			For State Registrar	State of Maryland		rtment of H			giene ()   () Reg. No.	05998
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Month} Physician/ 08^{ay} 2010 20:42 PM Susan F. Mann Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico 27753 Leeward Dr. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🍱 F Days Hours Min 0910711955 54 Yrs Maryland Director 220-66-3122 Usual Residence of Decedent 23a or 28a-f shov ast be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **Examiner must** USA 21801 27753 Leeward Dr. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò þ 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exa Specify: 3 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) State of Maryland 4 Nurse Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Audrey Dorman Glen Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27753 Leeward Dr., Salisbury, MD 21801 item 27 other tra Charles Mann/spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth Green Acres Memorial 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2 16 10 Salisbury, MD 22 Name and Addi HOLLOWay 21. Signature of Funeral Service Lic Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and-trar Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Was an autopsy death? performed Yes 2 No 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 **L** No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Natural injury 5 Pending s after death. Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cery(fying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only op 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number ည 1454827

Registrar

State

31413 WINDSMPLACE PK SUITE W3 SALISBURY MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

90

WAR.

32 Registrar's Signatur

GITTELMEN

31. Date filed (Month, Day, Year)

FEB 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of N Registrar	Maryland / i	Departmei Certificat			lental Hy	giene Reg. No. 2 (	010	06000			
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of De	ath	V	3. Time of Death			
	Medic	cal	Robert Bryson					Februa		2010	2:22 A ^M			
	Examin	er	4a. Facility Name (if not institution, give street and number)  5677 Swamp Circle Road	)		Town, or Location	on of Death			y of Death e Arui	nde1			
	Funeral	1		Age (In yrs. last birt			der 24 Hrs.	8. Date of Bir	th	9. Birthp	place (State or Foreign			
	Director		217-38-9800	68	Yrs.	Days Hour	IS IVIIII.	09-20-	1941	Mary.	land			
	and show	ror	10a. State 10b. County	10c. City, Tow	n or Location					1	0d. Inside City Limits			
	Maryl 28a-f otifie	Director	MD Anne Arundel		De	eale					1 ☐ Yes 2 💢 No			
	ith the 3a or 1 be n	ralD	10e. Street and Number		10f. Zi				10g. Citizen of		itry?			
	ems 2	Funeral	5677 Swamp Circle Road  11. Marital Status 12. Was Deceden	t Ever in U.S.	13. Was Dece	0751 Hent of Hispanic	Origin? (Spec	cify Yes or No-	US.	Ce - Americ	an Indian			
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 M Married Armed Forces 1 Never Married 2 M Married Fyes Cive	ੂੰ № 1962–66	If Yes, spe	cify Cuban, Mexi 2 X No S <i>p</i> ec	ican, Puerto F	Rican, etc.)		ack, White, e	etc.			
5-0	2 hour <b>"natu</b> edical	Completed	15. Decedent's Education (Specify only highest grade completed)		. Decedent's Usu (Give kind of wo	rk done durina n	nost of workin	ng	16b. Kind of E	Business Inc	dustry			
121	ithin 7 ene. r than the Me	Com	Elementary/Seconday (0-12) College (1-4 or 12)	r 5+) <b>M</b> a	ife.DONOTus Ster Plı	retired)			Contra	_	Heating			
bu	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)	1			other's Name	(First, Middle,	Maiden Surnam	ne)				
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<u>m</u>	Page ment o ant: If ury or		1 $X$ Burial 2 $\square$ Cremation 3 $\square$ Removal from Stat 4 $\square$ Donation 5 $\square$ Other (Specify)		ry, crematory or c ames' Pa		02-15	-2010	Lothia	an, MI				
Baltimore, Maryland 21215-0036	Home, 207													
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Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	1 Yes 2 No 4 Pregnant	at time of death	n 3 🗌 Ectopic 5 🗎 Other (s)					ate of delive onth	ry Day Year			
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	Pot Com		29b. Signature and title of certifier	000		License numbe			29d. Date signe					
			Marvey Johnfeld Mp 105158 2/15/2010											
9K	W Intl		30. Name and address of person who completed case of death (Item 23a) (Type, Print) 6/3/5/10/5/10/5/10/5/10/5/10/5/10/5/10/5/											
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